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**Helping the 'Problem Child' Become Loveable Again?  
A Discourse Analysis on Childhood ADHD in  
Switzerland and Implications for Social Work**

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Doctor of Philosophy  
The University of Edinburgh  
2020



## To the Reader

«You say:

—*Dealings with children are tiresome.*

*You're right.*

You say:

—*Because we have to lower ourselves to their intellect. Lower, stoop, bend, crouch down.*

—*You are mistaken.*

*It isn't that which is so tiring. But because we have to reach up to their feelings. Reach up, stretch, stand on our tip-toes.*

*As not to offend.»*

Janusz Korczak (1992, p. 3)



## **Dedication**

I dedicate this thesis to my parents Heidi and Fritz, who, above giving me roots, helped me to stretch my wings. And to my brothers Marc and Michel who are not only brothers, but true friends. Well, what may I study next?



## **Abstract**

Diagnoses and treatment of attention deficit hyperactivity disorder (ADHD) in children have seen significant increases in many parts of the world in the past two decades. However, there is a paucity of research on how this concept is increasingly being used around the world, as existing research on ADHD has often focused on the US and the UK contexts. Furthermore, the adoption of a governmentality perspective has largely been under-exploited in discursive research on ADHD, although there are notable exceptions.

This thesis explores these gaps by elaborating upon the concept of childhood ADHD in the context of Switzerland. It focuses on the media, the political and the parents' advocacy discourse planes, paying attention to both the historical emergence and the current presentation of childhood ADHD.

This research is guided by an overarching research question as well as three more specific questions. The overarching question is: How has the concept of childhood ADHD been established and maintained in the discourse in Switzerland to date? The more specific research questions are:

- (i) How are children labelled with ADHD rendered knowable and governable?
- (ii) How are children labelled with ADHD conceptualised and represented?
- (iii) How are children labelled with ADHD governed towards specific ends?

Data collection included 1139 media articles, with a particular focus on visual data, 214 pages of parliamentary discussions, two federal reports and 82 articles published by a parent advocacy group. In the light of a hermeneutic approach, further data sources, including guidelines, complaints, consultation papers and books, were identified and analysed as part of this research. The data were analysed using Foucauldian discourse analysis, focusing on analytical dimensions informed by the wider governmentality literature,



including the visual and spatial aspects of discourses, the rationalities embodied in discourses, the cultivation of subjectivities through discourses, and the technical aspects of discourses.

The results illustrate how rather vague research findings regarding ADHD are presented as objective, scientific facts. In this context, the discursively constructed prevalence rate of ADHD is identified as particularly important in transforming political agendas into apparently apolitical ones.

The findings further highlight how the image of the 'ADHD child' is constructed alongside (visual) representations of deviance, distress and self-governance. The common threads running through these representations are the ideas of the malleability and perfectibility of children, and how these may be employed to foster advanced liberal subjectivities.

Moreover, the results illuminate how children are governed through and within social spaces, i.e. the school, the family and leisure, suggesting that these are increasingly being meshed through the use of 'play' for both educational and therapeutic purposes.

Overall, the findings illustrate how knowledges around ADHD are entangled with power, giving voice to 'experts' and parents who are receptive to the medical model, while simultaneously marginalising opposing views. Additionally, findings illustrate that both children and social workers are almost completely absent in the discourse on childhood ADHD in Switzerland.

This thesis proposes that the way we construct childhood has real consequences for children. While the move from psychoanalysis to pharmacology has shifted the blame from mothering to the 'brain', and re-conceptualised children from being 'bad' to being 'ill', the findings suggest that suppressive forms of governing their behaviour seem to persist.

## **Acknowledgements**

I would like to thank my supervisors Viv Cree, Steve Kirkwood and Sumeet Jain. Receiving feedback from three different angles was not only challenging but truly inspiring. The support I received went well beyond what I could have hoped for and made this journey a smooth and enjoyable one.

Furthermore, I would like to thank Karen Wells for her introduction to International Childhood Studies at Birkbeck, University of London, well before I embarked on the journey of doing a PhD. Her teaching has had a lasting impact on my thinking. It inspired this thesis and continues to enrich my advocacy work at the United Nations and beyond.

Moreover, I would like to thank Rory Truell, Secretary-General of the International Federation of Social Workers, for allowing me to work from anywhere around the globe and at any point of time, so as to align paid work with the requirements of this PhD course. His words of encouragement truly enriched this journey.

Finally, I would like to thank my family, as well as friends from all over the globe, for their encouragement throughout this adventure. Ubuntu - I am because we are!



# Contents

To the Reader .....	iii
Dedication .....	v
Abstract .....	vii
Acknowledgements .....	ix
<b>1 Introduction .....</b>	<b>1</b>
<b>Background .....</b>	<b>1</b>
<b>Structure of the Thesis .....</b>	<b>3</b>
<b>2 Literature Review .....</b>	<b>9</b>
<b>Introduction .....</b>	<b>9</b>
<b>Contextualising ADHD .....</b>	<b>9</b>
The Rise of the Social .....	10
New Social Studies of Childhood .....	25
Summary .....	33
<b>Genealogising ADHD .....</b>	<b>33</b>
Supposed Flags of Primordial ADHD .....	34
The Shift from Psychoanalysis to Pharmacology .....	35
Moving Towards a Diagnosis Called ADHD .....	36
Summary .....	40
<b>Popularising ADHD .....</b>	<b>40</b>
Central Drivers of the ADHD Phenomenon .....	40
The Voice of ‘Experts’ in Medicine .....	47
Summary .....	51
<b>Problematizing ADHD .....</b>	<b>52</b>
Medical Practice .....	53
Environment .....	57
Children’s Rights .....	65
Summary .....	69
<b>Conclusion .....</b>	<b>69</b>

<b>3 Methodology .....</b>	<b>73</b>
<b>Researcher's Perspective .....</b>	<b>73</b>
Definition of Childhood .....	77
<b>General Discursive Approach .....</b>	<b>77</b>
Introduction.....	78
Main Concepts and Ideas.....	79
Strengths and Limitations .....	83
<b>Data Collection.....</b>	<b>87</b>
Introduction.....	88
Mass Media Communications .....	89
Parent Advocacy Association 'Elpos' .....	92
Parliamentary Database .....	93
Further Data Sources .....	94
<b>Data Analysis .....</b>	<b>95</b>
Noticing, Collecting and Thinking .....	95
The Structure of Discourses .....	98
Analytic Strategies.....	100
Translation of non-English Data .....	109
<b>Summary.....</b>	<b>111</b>
 <b>4 Rendering Children Knowable Within Relations of Knowledge and Power .....</b>	 <b>113</b>
<b>Introduction .....</b>	<b>113</b>
<b>Numbers .....</b>	<b>115</b>
The Political Dimension of Numbers .....	115
Epidemiology and Prevalence Rates.....	117
Numbers as Diagnostic Instruments.....	122
Summary .....	125
<b>Diagnosis.....</b>	<b>125</b>
Rendering the 'ADHD Brain' Visible .....	125
The German Guideline on ADHD .....	128
Summary .....	138

<b>Treatment</b> .....	<b>138</b>
Promoting Psychotropic Drugs .....	139
Evidence Regarding Pharmacological Interventions.....	140
Summary .....	145
<b>Signs of Power/Knowledge Relations</b> .....	<b>146</b>
The Privilege to Prescribe.....	147
Wider Actor Network.....	149
Claims to Neutrality and Objectivity .....	154
Discursive Limits.....	156
Summary .....	159
<b>Conclusion</b> .....	<b>160</b>
 <b>5 Conceptualising Children Alongside Idealised Images of Childhood</b> .....	 <b>165</b>
<b>Introduction</b> .....	<b>165</b>
<b>Representations of Deviance</b> .....	<b>166</b>
Defining Deviance.....	167
The Cultural and Political Dimension of Deviance .....	171
Risk Based Technologies of Government.....	173
Summary .....	175
<b>Representations of Distress</b> .....	<b>175</b>
From Unwilling to Unable.....	176
Distress as a Decisive Element .....	182
Summary .....	186
<b>Representations of Self-Governance</b> .....	<b>187</b>
Defining Good Behaviour.....	187
Becoming One's True Self .....	191
Performing Advanced Liberal Subjectivity .....	196
Summary .....	202
<b>Conclusion</b> .....	<b>202</b>

<b>6</b>	<b>Governing Children within Social Spaces .....</b>	<b>209</b>
	<b>Introduction .....</b>	<b>209</b>
	<b>School .....</b>	<b>210</b>
	Discipline .....	213
	Optimisation .....	220
	Normalisation .....	223
	Summary .....	230
	<b>Family.....</b>	<b>230</b>
	The Family as a Site of Government .....	231
	From Mother Blaming to Forced Screening and Drugging .....	235
	Summary .....	240
	<b>Leisure .....</b>	<b>240</b>
	Governing through Leisure .....	241
	Children's (Autonomous) Use of Space.....	245
	Summary .....	248
	<b>Conclusion .....</b>	<b>248</b>
<b>7</b>	<b>Discussion .....</b>	<b>257</b>
	<b>Summary of Main Findings .....</b>	<b>257</b>
	Rendering Children Knowable and Governable .....	258
	Conceptualising and Representing Children .....	261
	Governing Children towards Specific Ends .....	265
	<b>Implications for Social Work.....</b>	<b>268</b>
	Introduction.....	269
	The Social Construction of Health and Illness .....	271
	The Entanglement of Power and Knowledge .....	273
	The Emphasis on Distress and the Marginalisation of Context .....	275
	The Role of Mass Education .....	278
	Conclusion.....	281
	<b>Perspectives for Social Work.....</b>	<b>281</b>
	Introduction.....	282
	Praxeological Perspective .....	283

Emancipatory Perspective .....	287
Reflexive Perspective .....	290
Conclusion .....	291
<b>Limitations .....</b>	<b>292</b>
<b>Future research .....</b>	<b>294</b>
<b>Reflections .....</b>	<b>296</b>
<b>Conclusion .....</b>	<b>297</b>
 <b>Bibliography .....</b>	 <b>301</b>
 <b>Appendices .....</b>	 <b>345</b>
Appendix A: Newspapers Used for Data Collection.....	346
Appendix B: Brief Introduction to the Swiss Parliament .....	350



# List of Figures

Figure 1	Political enquiries across time	93
Figure 2	Image analysis	96
Figure 3	Iterative process of Noticing, Collecting and Thinking, adapted from Seidel (1998)	98
Figure 4	Esoteric and exoteric circle, adapted from Lima et al. (2018)	108
Figure 5	'Supply of Methylphenidate to the market in Germany and Switzerland' (Straumann, 2015)	115
Figure 6	'Visualised brain activities during deep sleep' (Stallmach, 2015)	126
Figure 7	'For years Jan had to take Ritalin. In the meantime, he was able to stop taking the medication' (Schirm-Gasser, 2015a)	139
Figure 8	Proportional visualisation of the sources of evidence underlying the recommendations of the German Guideline on ADHD (DGKJP et al., 2018b)	142
Figure 9	"Ritalin: General practitioners are not critical enough of the 'miracle drug'" (Habicht, 2009a)	147
Figure 10	Network of actors driving the ADHD phenomenon	152
Figure 11	'Outbursts of anger in children can be perfectly normal, says Allen Frances' (Straumann, 2013)	167
Figure 12	'Children with ADHD have great difficulties in learning' (Leuenberger, 2010)	176
Figure 13	"Nine-year-old Kilian suffers severely from the symptoms of ADHD and takes a high dose of a Ritalin-like drug. The pressure of school puts him under a lot of strain. His deepest wish: 'To be able to write more beautifully'" (Jeitziner, 2011)	188
Figure 14	'ADHD children are distracted more quickly and often react unexpectedly and impulsively' (Hirschberg, 2011)	212
Figure 15	'It is difficult for many children to sit quietly during homework' (Straumann, 2012)	232
Figure 16	'Seven-year-old Maximilian is concentrated on the chessboard. Before he found his way to the game of kings, he was a very lively child' (Zilic, 2011)	241
Figure 17	Triple mandate of social work, derived from Schmocker (2019)	286
Figure 18	Collage of images featured and analysed in this thesis	298

## List of Tables

Table 1	Search terms	90
Table 2	Overview of collected newspaper items	91
Table 3	Overview of selected newspaper items and visual data	92
Table 4	Political enquiries regarding Ritalin use and ADHD in Switzerland	93
Table 5	Main characteristics of the mandates of social work derived from Schmocker (2019)	287



# 1 Introduction

This chapter introduces the background of this research, briefly discusses the structure of this thesis and concludes with some notes on the presentation of data and the use of cross-references.

## Background

In 1971 an advert of a pharmaceutical company claimed that “Ritalin helps ‘the problem child’ become lovable again” (Ciba-Geigy, 1971, p. 108). With reference to several concepts, including Hyperkinesis, Minimal Brain Dysfunction and Functional Behaviour Problems, the advert further claimed that

[w]hatever the terms used to identify the affliction, many investigators confirm that Ritalin... helps control the child's hyperactivity, increase his verbal productivity and attention span, improve his behaviour and learning abilities (ibid., p.108)

All these terms therefore refer to behaviour displayed by children and centre around the ideas of ‘hyperactivity’ and (lack of) ‘attention’ in children. More recently, though, the term Attention Deficit Hyperactivity Disorder (ADHD) has become dominant in the discourse around these ideas (Prout, 2005), and has replaced Hyperkinesis in the classification of the World Health Organisation (Reed et al., 2019). Yet, as Conrad and Bergey (2014) observe, the ADHD diagnosis was primarily used in North America, and has only gained significant international popularity during the last two decades. Evidence suggests that the concept of ADHD is, meanwhile, well established in a number of countries (Cohen, 2006a), particularly in what Punch terms

the 'minority world', i.e. those nation states that are economically well off (2003, p. 278). Although the majority of children live in economically poor world regions, it is, paradoxically, their childhoods that are considered 'deviant' in the light of a western idealised conceptualisation. Borrowing from Punch, I will consequently refer to these nation states, that are often conceived of as 'developing countries', as 'majority world'. While these terms inevitably unduly homogenise both world regions, I follow Punch in using them as a means to invite 'reflection on the unequal relations between them' (ibid., p.278). The 'impending globalization' (Conrad and Bergey, 2014, p. 31) of ADHD has, however, not gone unnoticed. For instance, in 2015 the United Nations Committee on the Rights of the Child (hereafter Committee) expressed its concerns regarding the

excessive diagnosis of attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD) and the ensuing increase in the prescription of psychostimulant drugs to children, in particular methylphenidate, despite growing evidence of the harmful effects of these drugs (2015, p. 14)

The Committee recommended that Switzerland carry out research in order to reveal the causes of inattention in the classroom, and to identify non-drug approaches to ADHD. Moreover, the Committee's concluding observations highlighted the need to ensure that all relevant stakeholders working for and with children are provided with adequate information on ADHD (ibid).

ADHD is one of the most common diagnoses in children (Abrines et al., 2012; Conrad and Bergey, 2014). However, the inconsistency of diagnostic processes and guidelines and the growing concerns regarding the use of psychotropic drugs (such as Ritalin) to treat ADHD mean that this disorder remains one of the most debated childhood diagnoses around the globe (Singh, 2011). Acknowledging that ADHD remains a controversial entity, this study aims to identify and critically analyse both hegemonic and 'counter discourses' (Jäger and Maier, 2010) and to discuss them in the light of social work as a human rights based profession (Schmocker, 2019; Staub-Bernasconi, 2011, 2007).

This study focuses on the discourse on childhood ADHD in Switzerland, which is considered a site where ADHD has been well established (Cohen, 2006a). Switzerland is particularly interesting as a research site since it is constituted of four language regions (Swiss German, French, Italian, Romansh). This makes it possible to examine whether there are cultural differences across these regions in adopting the concept of childhood ADHD. Suggesting that the conceptualisation of 'disorders' may best be understood as a modern art of government (Tait, 2006), this thesis uses a governmentality perspective (Dean, 2010; Foucault, 1991a) in order to analyse how the concept of childhood ADHD has been established and maintained in the discourse in Switzerland. The study engages with different social locations from which speaking about ADHD takes place, including the media, politics and advocacy groups.

Although ADHD is intensively researched, there is a general paucity of research into how the concept is being adopted around the world (Conrad and Bergey, 2014). While there are some discursive studies on childhood ADHD, the focus has been primarily on North America (Faraone et al., 2003; Polanczyk et al., 2014). Additionally, to my knowledge, no research has yet applied a governmentality perspective to examine the discourse on childhood ADHD in Switzerland.

## **Structure of the Thesis**

Following this introduction, Chapter Two provides a review of relevant literature around the discourse on childhood ADHD. It engages with existing research on four distinct but related perspectives. Firstly, some wider discourses that enabled the emergence of ADHD, including the introduction of compulsory schooling and the institutionalisation of public health, are discussed. Secondly, a genealogical perspective is adopted to elaborate upon the emergence of concerns around and shifts in the understanding of 'deviant behaviour' in children. Thirdly, some key drivers of the popularisation of childhood ADHD are identified, and possible differences between Switzerland and North America (where much of the available literature is

focused) are discussed. Fourthly, the concept of childhood ADHD is problematised by drawing on a range of disciplines, including sociology, anthropology and social work.

The third chapter explains the methodological approach underlying this research. It starts with some considerations regarding my 'researcher's perspective' (i.e. my personal values, interests and assumptions). This is followed by a discussion of the general discursive approach taken, including its strengths and limitations. Inspired by the work of Foucault (1989, 1991a, 2001, 2002) and the wider governmentality literature (Dean, 2010; Inda, 2005; Rose, 1999), this research takes an approach that is most closely aligned with what Carabine (2001, p. 281) termed a Foucauldian Genealogical Discourse Analysis and thus highlights the historical dimension of discourses. I emphasise that, within this perspective, discourses are regarded as producing knowledges and 'truths', being enmeshed with power relations, and actively constructing social realities. The chapter then goes on to describe the data, and to explain why those data are suitable to answer the research questions. Furthermore, the iterative approach to data collection and data analysis, which is derived from Seidel's (1998) model, is introduced. The chapter concludes by introducing some analytical concepts that have been of key relevance for this project. More specifically, I discuss how the analysis was informed by a dimensional approach that aims to emphasise the visual, spatial and technical aspects of discourses, as well as the rationalities they draw upon (for instance developmental psychology) and the subjectivities they aim to cultivate (for instance, the schoolchild). Finally, the concepts of 'thought style' and 'thought collective' (Fleck, 1979), which are useful tools in analysing social interaction in scientific communities underlying the production of 'scientific facts' (for instance that ADHD has a fixed prevalence rate), are introduced.

Chapter Four represents the first 'findings' chapter and illustrates how 'truth' around childhood ADHD is built to render children knowable and governable. The examination of these knowledges and 'truths' takes place alongside

emerging topics in the data, including (the political dimension of) numbers, diagnostic tools and practices and treatment recommendations. A significant proportion of this chapter examines the *German Guideline on ADHD* (DGKJP et al., 2018a) and argues that although this guideline is described as being based on scientific evidence, it rather represents preferences in the clinical practice of medics. The chapter concludes with a discussion of how relations of power give voice to some 'experts', while simultaneously limiting what is sayable about childhood ADHD at a certain point in time. In particular, the claims of neutrality and objectivity of the parents' advocacy association 'Elpos' and possible conflicts of interest of 'key opinion leaders' in the field are problematised.

Chapter Five illustrates how the image of children labelled with 'ADHD' is constructed along three emerging themes of 'deviance', 'distress' and 'self-regulation'. Drawing on theories from the new social studies of childhood, the analysis of these themes suggests that children are governed towards an idealised image of an advanced liberal subjectivity that emphasises agency and participation, but also responsibility and reflexivity (cf. Smith, 2012). The findings suggest that the common threads running through these conceptualisations of childhood are the ideas of the malleability and perfectibility of children, and how these may be employed to foster advanced liberal subjectivities. While children displaying 'deviant behaviour' are no longer considered 'bad', but rather as being 'ill', the findings suggest that labelling processes and the possible stigmatisation they bring seem to persist.

Chapter Six explores how the spatial and temporal design of social spaces, including the school, the family and leisure, aims to govern children. The results illustrate how certain characteristics of the school, including earlier recruitment and transitions (such as from pre-school to school, and from primary to secondary school) seem to drive both diagnosis and treatment practices in childhood ADHD. This chapter further illustrates how technologies of discipline, optimisation and normalisation that are common in



schools are being extended into the family home. Moreover, the findings of the discourse around ADHD suggest that leisure and therapy are increasingly being meshed, making it difficult to draw a distinction between work, leisure, education and socialisation.

Chapter Seven draws together the conclusions of the three findings chapters and relates these back to both theory and previous research. It then goes on to discuss implications for social work, including the role of mass education in the wellbeing of children, the emphasis on individual distress and marginalisation of environmental context, the entanglement of power and knowledge, and the social construction of health and illness. This is followed by a discussion of possible praxeological, emancipatory and reflexive perspectives for social work. Building on social work as a human rights based profession (Schmocker, 2019; Staub-Bernasconi, 2011, 2007), some avenues towards anti-discriminatory and anti-oppressive practices are discussed. This last chapter further discusses limitations, indicates pathways for future research, and offers some reflections on the research process with reference to the 'researcher's perspective', as discussed in Chapter Three.

To conclude this chapter I would like to briefly introduce the reader to some characteristics of this thesis in terms of presentation of data and navigation throughout this document. Firstly, all data analysed are in a language other than English (i.e. German, French and Italian). Hence all quotes are translations of the original texts. Where translations have been challenging I have indicated this by presenting a specific term in the original language in brackets, e.g. 'social pacification {soziale Befriedung}'.

Secondly, this thesis aims to detach statements from specific people. Hence all data presented are anonymised. However, to give some context, the professional background of people quoted is indicated (e.g. journalist, psychologist, etc.). Obviously, the identification of these people is nevertheless possible as the sources of quoted texts are fully indicated.

Thirdly, although the focus of this thesis is on social work, there are few references to social work in the findings chapters. This is mainly due to the almost complete absence of the voice of social work in the discourse on childhood ADHD in Switzerland, at least in the social locations this thesis is focusing on (i.e. texts from the media, the political and the parents' advocacy discussion). However, this will be returned to in the discussion chapter, where both implications and perspectives for social work are discussed.

Finally, to make navigation between chapters easier, I have inserted clickable cross references (to demonstrate this, here is a link to the next chapter, **Literature Review**, p.9). After clicking on a link, navigation back to the previous location in the document is possible by pressing 'Alt' + 'Left Arrow' on the keyboard or by using the relevant button of the PDF reader. For those printing this document, the page number following a cross reference also points to the relevant location.



## **2 Literature Review**

### **Introduction**

As I have mentioned in the introduction, this thesis focuses on Switzerland. Much of the research on ADHD, though, has been conducted in North America and, to a lesser extent, the UK. This review of the literature acknowledges both the wider body of research around ADHD and introduces, where available, specific research conducted in Switzerland.

This chapter is structured around four sections. First, some broader discourses around children and childhood are introduced to situate the idea of ADHD within wider discursive contexts. In addition, this first section aims to introduce some concepts and ideas that will then enrich the discussion in the three findings chapters. The review continues by offering some exploration of the genealogy of the ADHD discourse. I argue that the shift from psychoanalysis to pharmacology designates an important event in the proliferation of medicalised concepts in mental health. The review then turns its focus to how the idea of ADHD is being popularised both on a national (i.e. Switzerland) and a global level. Finally, the concept of ADHD as a 'given truth' (Tait, 2006) is problematised by including critical accounts from a range of disciplines, particularly sociology, anthropology and social work.

### **Contextualising ADHD**

This first section of the literature review aims to contextualise the discourse on ADHD within wider discourses. Firstly, a discussion of the 'rise of the social' (Deleuze, 1980) aims to indicate how the introduction of compulsory

schooling and the institutionalisation of public health fostered ideas of standardised development in children. Secondly, an introduction to more recent perspectives on children, under the umbrella of what has been called the new social studies of childhood, is offered. This section aims to lay the ground for the genealogy of ADHD, discussed later in this chapter, and to facilitate analysis and discussion throughout the findings and discussion chapters.

## **The Rise of the Social**

From the late 18<sup>th</sup> century to the early 20<sup>th</sup> century the interconnecting processes of industrialisation and urbanisation in the minority world led to a massive increase in families moving to cities. Poverty, poor housing and ill health were widespread in working-class families, and children worked from a young age alongside their parents in the new factories and mills (McNamee, 2016). Yet, the introduction of compulsory education increasingly sought to remove children from factories and streets (Cunningham, 2005). Let us consider this in more depth.

### **Introduction of Compulsory Schooling**

As Hendrick (1997) argues, the introduction of compulsory schooling sought to produce a standardised, 'national' childhood, i.e. one that, at least theoretically, ignored social class and the division between urban and rural spaces as now all children were enrolled into education (I will turn to the Swiss context on p.15). He argues that the school introduced a number of mechanisms to produce the kind of children that the State was aiming to get, including the spatial separation of children from the wider society and the use of various disciplinary measures to enforce docile behaviour. These mechanisms, in turn, increased children's dependence on adults, as they were now excluded from waged work. The introduction of compulsory schooling led also to a shift in the perception of child labour. While it used to be considered exploitation by adults, the new paradigm rendered working children as morally weak and out of their proper space, and accordingly needing to be acted upon through the institution of education. Schooling,

therefore, was the crucial technology to invest 'in future parenthood, economic competitiveness, and a stable democratic order' (Hendrick, 1997, p. 44). The technology of schooling depends on specific techniques, particularly disciplinary and normalisation measures. Let us briefly consider these in turn.

### **Discipline**

In his seminal work *Discipline and Punish*, Foucault (1989) described the disciplinary powers of the school and compared them with those of other institutions, including the prison. Discipline, thus, is aimed at increasing the economic value of children's bodies, and at diminishing their resistance to political programming. But ever since the introduction of free compulsory education, teachers have been confronted with a mass of children either unwilling to subject themselves to scholastic discipline or not well prepared for it (Donzelot, 1980). Their challenging behaviour and underachievement have presented teachers with significant problems. Nevertheless, discipline plays a pivotal role in schools and is generally enforced through controlling time, space and the individual bodies of children (McNamee, 2016).

### **Control of Space**

The control of space, through the distribution of schoolchildren within schools, reflects the superiority of adults and endows them with the power to control children (Devine, 2002). While children are excluded from certain spaces, such as offices and staff rooms, their move through and use of space is closely controlled. In the classroom the distribution of individual bodies follows a certain logic, which Foucault described as an 'art of rank' (1989, p. 146). For example, those children who are well behaved and hard-working may be placed at the back of the classroom, while those who lack these attitudes may be placed near to the teacher for close surveillance. Other considerations regarding the spatial distribution of school children in the classroom include individual 'progress, worth, application, cleanliness and parents' fortune' (ibid., p.147). Through the panoptical arrangement

(ibid., p.195) of desks within the classroom, children are at all times exposed to the gaze of the teacher.

### **Control of Time**

Another important dimension of discipline in schools is the management of children's education through time. The timetable establishes rhythms, imposes particular exercises and regulates the cycles of repetition (Devine, 2002). The rationale here is to make time as useful as possible. Deviant behaviour such as daydreaming, chatting or fidgeting, arguably some of the core features of what has been described as 'ADHD', consequently potentially undermines both the spatial and timely distribution of bodies and tasks. The aligning of tasks with time allows detailed control and regulation of the classroom through techniques such as differentiation, correction and punishment.

### **Control of the Body**

Until recently corporal punishment played an important role in the management of children's bodies (I will discuss this in the third findings chapter, see **Discipline Through the Control of the Body**, p.218). As Simpson (2000) argues, the body and bodily discourses are central to the power relations within schools. In her ethnography she identified numerous occasions where children were urged into docile behaviour:

sit up and sit still, eyes to the front, button your mouths, pin back your ears, engage your brains, calm down and listen (ibid., p.68)

A high level of bodily self-control, therefore, is regarded as maturity in children. If they adapt to the strict rules of the school and perform a high level of self-control, pupils are regarded as good citizens in the making. Children who do not meet these disciplinary requirements of the school are problematised in a dual pathology. They are seen both as children at risk and as being risky children (I will expand on this later in this chapter, see, **Risk and Prudentialism**, p.22). It is against this duality that contemporary perceptions of how and when to control and discipline children are legitimised (Caputo, 2007). Much of the discipline imposed on schoolchildren is

consequently about controlling their bodies. At the same time, much of the resistance children show is through using their bodies, for example by making noise and pretending that they have to sneeze. They may also use the bathroom during lessons to contravene the usual 'spatial-temporal ordering of the school' (Christensen and James, 2001, p. 79).

### **Normalisation**

As Foucault (1989) suggests in his account *Discipline and Punish*, normalisation seeks to construct an idealised norm of conduct. If children at school deviate from such norms, they may face punishments. More recently, in the wake of shifting understandings of the child (I discuss this in more depth later in this chapter), there has been a shift away from regarding children as 'bad', at least in the minority world. Rather, they are now regarded as suffering from a certain pathology. In order to normalise their conduct children are subjected to certain processes, including assessment, pathologisation and inclusion. Let us briefly consider these in turn.

### **Assessment**

Assessment is an important, recurring technique in the contemporary government of children (Smidt, 2005). Literally moments after birth some first tests are conducted on the infant. Regular screenings aimed at closely monitoring the development of children follow during the years after and at the end of pre-school, the child is assessed regarding their preparedness for school. This is then followed by ongoing measures throughout the time a pupil spends at school. A particularly potent technique for the management of children in the classroom is the examination. As a 'normalising gaze' (Foucault, 1989, p. 184), it combines the techniques of observation with that of normalisation. This form of surveillance enables teachers to classify children on an ongoing basis. Children labelled with ADHD, though, tend to resist routine tasks, such as monotonous schoolwork (Sadek, 2013). It is somewhat ironic, however, that guides on ADHD for teachers tend to focus on even stricter structures and time management (see, inter alia, Reid and Johnson, 2011). Increasingly, school social workers (see, inter alia, Corcoran



and Walsh, 2016; Openshaw, 2007) are involved in such assessment approaches (Rose, 1999).

### **Pathologisation**

The emphasis on the universal development of children (I discuss this in more depth later in this chapter) arguably led to an exaggerated sensibility to even the smallest of deviations (Bühler-Niederberger, 2005), and thus to an increased amount of intervention by a range of occupations, including teachers, psychologists, paediatricians, child psychiatrists and social workers. Within this context the idea of 'ADHD', among many other 'pathologies', serves as a means to generalise treatment approaches and potentially affects an ever-growing population of pupils. This, in turn, produces a wide range of special needs services, including school social work, school psychology, speech therapy and play therapy.

### **Inclusion**

Once the child has been assessed and pathologised, the final step in the normalisation process is to include them in the 'normalised' space of the school. Inclusion, in this context, designates a recent shift in educational policy and practice (Strasser, 2006). Historically, the idea of integrating the child into society through shaping them into a productive adult was, at least in part, achieved through segregating children with 'special needs' into distinctive schools. Yet, more recently, the focus has shifted towards inclusion, which aims to educate all children in mainstream schools and to prevent the segregation of children because of their 'special educational needs' (ibid.).

### **Education and Structural Violence**

Violence caused by social, economic and cultural factors, and the settings shaped by these, may be considered as structural in nature. According to Galtung (1969), 'structural violence' may cause avoidable impairment in both children and adults. From this point of view, the (re-)production of social inequalities and gender differences through education, and the inequalities and social injustice that result from it, may be regarded as violence. Scholars

within the field of sociology have been problematising schools for their avoidable structural violence. For example, Williams (2005) has explored how the administrative processes and placements into alternative schools potentially harm children, and Fuchs et al. (2013) point to how the wider societal imbalances in the relationships between children and adults affect the daily interactions between teachers and pupils. Other notable work from the sociology of education, though not specifically drawing from the perspective of structural violence, has highlighted how the school fails to reduce social inequality. Paul Willis (1977), in his seminal ethnography on white working-class boys, showed how the school fails these children in terms of social mobility, while the work of Cookson and Persell (1987) focused on the school as a site for the reproduction of the social and economic elite. More recent work in this field has focused on the intersectionality of gender, 'race' and class in the reproduction of social inequality (Bettie, 2014; Ochoa, 2003). Again, from a different angle, a group of psychologists and psychiatrists around Langberg et al. (2008) suggested that environmental changes associated with transitioning to middle school coincide with an increase in 'inattention', 'hyperactivity' and 'impulsivity' in children labelled with ADHD, in spite of the pharmaceutical regime they have been subjected to.

### **The Case of Switzerland: Federalist Plurality in Search of Harmonisation**

As in many countries of the minority world (and, more recently, the majority world), Switzerland was part of the movement towards compulsory schooling. However, due to its federalist structure, there is no single history of Swiss education (Hofmann, 2014). Rather, there are a number of histories of different cantons across Switzerland. For example, there are records of early public education in the Canton of Berne dating back to 1218 (Egger, 1953). These early schools focused on religious education and were part of the Roman Catholic Church. The reformation of 1548 shifted the content of education towards Protestant thought and beliefs, and schools remained largely religious institutions. In 1848 the then 25 cantons united under a federal constitution (in 1979, the canton of Jura was formed, increasing the

number of cantons to 26). However, these cantons remained largely sovereign. The federal government of Switzerland accordingly has very limited power in terms of education and, as a consequence, school systems developed under cantonal authority (Im Hof, 2007). Cantonal differences in teaching materials, age of mandatory schooling and styles of lettering made it difficult for families to move from one canton to another one because of the '26 school systems' (Stamm et al., 2011). Some of these obstacles regarding mobility across cantonal education systems remain to date.

More recently, though, there were attempts to harmonise the education system of Switzerland across cantonal borders. In 2009 the Intercantonal Agreement on Harmonisation of Compulsory Education (hereafter Education Agreement) came into effect (cf. EDK, 2015). The Education Agreement increased the duration of compulsory education by two years and replaced the kindergarten with a 'first learning cycle', organised either as a pre-school or a mix of pre-school and school. Earlier enrolment has been linked to lower disparities between the educational achievements of children of lower and higher socio-economic backgrounds (Bieber, 2016; Schultheis et al., 2008). Yet, while school enrolment age varies significantly around the world, it does not explain cross-country difference in educational abilities (Rindermann, 2018). Nevertheless, there is a trend towards the earlier recruitment of children into formalised education. While the kindergarten in Switzerland was previously primarily a space to socialise with peers, it has now been reformed as a preparatory school, and this has led to the recruitment of children for compulsory education at the age of four. Before the implementation of the Education Agreement the kindergarten was non-compulsory, and many children entered it only at the age of six. The main focus of the reform lies in the introduction of 'performance standards' that describe skill levels 'that the pupils must achieve at a given time during compulsory education' (EDK, 2019). These standards must be 'measurable and testable' (ibid.). This reflects the contemporary, advanced liberal ideal of 'outcome based' measures in all areas of life (cf. Dean, 2010). Critics are concerned that such

an ideal reduces not only schools to outcomes but pupils themselves (Gleeson and Husbands, 2001).

The endeavour to identify deviations from the 'norm' in child development at an ever earlier age has also led to political debates about extra-familial early childhood care. Arguably, Switzerland is a rather conservative country regarding extra-familial care. Many families still choose to raise their children through their first four years at home until they reach the age to enter pre-school. However, more recent parliamentary debates have asked for an expansion of this sector and for more children to be recruited into institutionalised early childhood care, as a means of increasing the workforce by allowing (both) parents to combine work and family life (Bernet, 2010).

### **The Institutionalisation of Public Health**

Alongside the introduction of compulsory education, the institutionalisation of public health systems began to emerge in order to address concerns about children's physical and mental health. The hygiene movement led to the mass physical examination of schoolchildren across Europe (Hofmann, 2015). In this context, the 'psychological complex' (Rose, 1985) rendered public schools a site for monitoring and assessing children on a large scale. They developed standards against which the normalised development of children could be measured (I will elaborate upon this in more depth later in this chapter). To normalise children's development doctors proposed a great number of preventive and therapeutic interventions aimed at producing a healthy society. They presented a plethora of works concerning the rearing and education of children (Donzelot, 1980). In the long run, it was this body of knowledge that allowed medical doctors to consolidate their power and to align themselves with the State through integrating public health into the school system (Hofmann, 2015).

### **Governing Through Families**

The spatial reorganisation of childhoods in the minority world (and, more recently, the majority world), however, was not only concerned with removing children from factories and streets and enrolling them into public schools.

The family was regarded as equally important in the production of future citizens. In his genealogical account of the policing of families, Donzelot (1980) charted the rise of 'the social'. This hybrid sector, that is neither private nor public, was linked to other agencies, namely the judicial, the psychiatric and the educative. In the wake of this development, a new series of professions assembled under the banner of social work and took over 'the mission of civilizing the social body' (ibid, p.96). The school, then, 'became the avenue through which education, social work, and medicine became intertwined in terms of access to children and families' (McNamee, 2016, p. 75).

Through education and the 'social enquiry' (Donzelot, 1980) children became exposed to panoptic surveillance (Foucault, 1989) in both the school and the home, and their development was monitored. This led to a new alliance of medicine and the State, and a powerful network of actors emerged, aiming to govern children towards specific ends. These actors included medical doctors, psychologists, psychiatrists, social workers, educators, a range of therapists and judges. Together they formed what Donzelot (1980) calls the 'tutelary complex', a group of professions promoting 'welfare through advice' (McNamee, 2016, p. 76).

While families were 'liberated' from old patriarchal structures, they were simultaneously exposed to an ever-greater surveillance and government. In this new organisation of social space, parents and, again, mothers, were endorsed with a certain power over their families. This power, though, was subject to surveillance control. Furthermore, parents, and particularly mothers, were expected to follow the advice of the tutelary complex in order to keep their parental authority. The move to 'scientific mothering and child rearing' (ibid, p.76) therefore shifted power relations. No longer were mothers, but rather the members of the tutelary complex, seen as experts in child rearing. It is against this backdrop that, well into the middle of the twentieth century, psychiatrists, arguing from a psychoanalytical point of view, postulated that there are no lazy children but only ill or badly educated

ones (Donzelot, 1980). Hence, if the psychiatric assessment of a child revealed a discrepancy between abilities and scholastic performance, then the mother was to blame.

### **Homework**

The introduction of the technique of homework was the principal means of extending the medical gaze (Rose, 1999) and the panoptic surveillance (Foucault, 1989) into the sphere of the private home. Homework plays a pivotal role in the management and supervision of children in the social spaces of both the school and the family and aims to align these spaces with each other. As Edwards (2001) argues, throughout the last few decades an orthodoxy that promotes close partnership between parents and teachers has been developed. Arguably, this close collaboration of the school and the home has been institutionalised to the extent that it has become part of the wider social construction of what constitutes 'good parenting' (Vincent and Tomlinson, 1997). Consequently, parents, and particularly mothers, are seen as responsible for the educational achievements of their children. It is against this background that some children, in a study conducted in the canton of Geneva, reported that what their parents were most interested in was linked to homework (Montandon, 2001). Moreover, bringing back bad comments from the teacher or bad marks after exams was a major source of fear in children (ibid.).

### **Developmentalism**

McNamee (2016) argues that most of our common-sense thinking about children is, although often unconsciously, framed by a developmental understanding. At the core of developmentalism is the understanding that the child's progress to adulthood takes place as a series of age-related steps, and that all children go through these at the same age and in the same order. Through recruiting children into schools (see earlier in this chapter), a large mass of children could now be studied and the 'normal child' be 'distilled from the comparative scores of age-graded populations' (Burman, 2016, p. 23). In this context, Darwinism, and later the work of Jean Piaget (1971, 1964,

1952), was important in establishing what may be called “a ‘gold standard’ of the normal child” (James et al., 1998, p. 19). Since the child study movement (cf. Cunningham, 2005) took place in Europe and North America only, and largely with boys, this standard is significantly biased and does not account for the variety of children’s development across the globe. Even more recent research still fails to account for geographical differences and to examine how childhoods are shaped by social identities, such as class, gender and ‘race’ (Wells, 2009). Yet it is against the paradigm of a normal child that those children who do not develop according to the defined stages are labelled deficient. As a ‘science of the mind’ (McNamee, 2016, p. 25), developmental psychology aims to categorise and label those considered deviant. An important means of facilitating such labelling processes in children is clinical manuals, including the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013, hereafter DSM) or the International Classification of Diseases (World Health Organisation, 1994).

### **Diagnostic Criteria**

Such manuals rely on diagnostic criteria to facilitate diagnosis. According to *DSM*, these criteria are defined around a hierarchical model of elements, consisting of (i) symptoms, (ii) syndromes, (iii) disorders and (iv) diseases (Heiby, 2012). The simplest level is the symptom, an observable behaviour or state that does not necessarily imply an underlying problem or a physical aetiology. The next higher level of analysis is the syndrome, referring to a constellation of symptoms that occur together or co-vary over time. The term again does not carry direct implications regarding an underlying pathology. The idea of disorder builds on the above criteria, and like a syndrome, refers to a cluster of symptoms. As with symptoms and syndromes, there is no implication regarding aetiology. However, the term includes the idea that the set of symptoms is not accounted for by a more pervasive condition. Finally, a disease represents the highest level of conceptual understanding and refers to a disorder where the underlying aetiology is known (ibid.).

So far, no psychiatric condition has ever reached the level of a disease as per the model above. As Katona et al. (2015) argue, in medicine it is thus common to make a distinction between disease (which has an objective and demonstrable physical pathology) and illness (which is based on subjective distress). Against this backdrop, psychiatric conditions are described as illnesses or disorders rather than diseases. The hope here is that new technologies, including genetic research and neuroimaging, will identify biomarkers in the future. Nevertheless, despite 'the truly industrial scale of the research, no consistent route from gene to disorder has been found' (Wastell and White, 2017, p. 78) to date, and neuroimaging has been similarly unsuccessful (Hasler, 2013). Accordingly, the concept of mental illness is considered

useful in defining a level of subjective distress greater in severity or duration than occurs in normal human experience (Katona et al., 2015, p. 7)

It is in this context that diagnostic criteria, as described above, aim to 'set thresholds to define the level of symptoms that constitute mental illness' (ibid., p.7). While this difference may be helpful in the English language discourse, it may be rather confusing in the German speaking context, since both 'disease' and 'illness' translate into 'Krankheit'. This may potentially lead to considering rather vague 'psychiatric conditions', including 'ADHD', as being equal to diseases that have a known aetiology and demonstrable physical pathology.

For so called 'behavioural disorders', symptoms are generally described as behavioural patterns. Taking ADHD as an example, a list of 18 such symptoms in DSM-5, including '[i]s often forgetful in daily activities' and '[o]ften talks excessively' aims to facilitate diagnostic processes (APA, 2013, p. 59ff). The diagnostic criteria are followed by a paragraph on *Associated Features Supporting Diagnosis* that claims that '[b]y early adulthood, ADHD is associated with an increased risk of suicide' (ibid., p.61). This projection towards the future and the reference to associated risks is a significant element in the legitimisation of the assignment of a mental health diagnosis



and the treatment that follows it (I will elaborate upon this alleged relationship in some more depth in Chapter Five, see **Defining Deviance**, p.167). Let us briefly consider the broader significance of such projected risks.

### **Risk and Prudentialism**

As Ewald (1991) suggests, nothing is a risk in itself but anything can be a risk. There is no risk in reality but, through processes of ascription, phenomena such as the behaviour displayed in children may be associated with risk. Nevertheless, risk has become a major concept in the management of social order (Bailey, 2010). Ulrich Beck even suggests that we have moved from late industrialisation to a 'risk society' in the minority world (1992, p. 19). In what he terms 'reflexive modernisation', Beck suggests that the outcomes of modernity need to be examined in terms of their production of risks, which leads to constant public debates around risks and their effects (ibid., p.153ff). This, he argues, leads private lives to be dominated by concerns about risk. These concerns are exaggerated by individualisation processes. In the light of societal changes that post-industrialisation has brought about, crises are no longer regarded as being socially based but as individual problems. Advanced liberal ideas of subjectivity involve not only the freedom to choose but also the responsibility to make the right choices (ibid.). It is against this idea that Tulloch and Lupton (2003) argue that prudence, i.e. the active avoidance of risk, is understood as rational behaviour and as representative of a 'civilised body'. To take avoidable risks, consequently, is

seen as foolhardy, careless, irresponsible, and even 'deviant', evidence of an individual's ignorance or lack of ability to regulate the self (ibid, p.10)

While adults are concerned with most decisions about risks involving infants and young children, there is a progressive handing over of responsibility between infancy and adulthood (Adams, 2001). Although children are commonly known to be 'impulsive, energetic and frequently dis-obedient [sic]' and having 'short attention spans' (ibid., p.12), expectations set by idealised notions of advanced liberal subjectivity ask them to take responsibility in pre-

schools and schools for their own welfare at an ever-younger age. It is in this context that 'deviant behaviour' is regarded as serious troubles to come in the future, including un-employability, deviance and criminality (Bailey, 2010). Children displaying 'deviant' behaviour in schools are therefore regarded as both risky (in terms of their effects on other children and adults) and as being at risk (of educational failure).

The combination of the idea of 'normal development' and risk, consequently, serves as an important means in the contemporary governance of children. In what Dean termed 'case management risk' (2010, p. 218), epidemiological rationalities of risk interpretation and management are combined with techniques of diagnostics and therapeutics. Case management of risk includes the qualitative assessment of children through technical means, including interviewing, psychometric testing and the 'exercise of bureaucratic judgements' (ibid., p.219) in schools or the clinical judgement of medical doctors. The development of knowledges around the idea of normal development, and the techniques to manage risk in populations, enabled certain occupations to position themselves as experts regarding the government of children. This has been elaborated upon in sociological accounts of professionalism. Let us briefly consider the nature of these relations between professionalism, development and risk.

### **Professionalism**

As mentioned above, the introduction of compulsory schooling and public health systems enabled members of the tutelary complex to generate large data on children and, in turn, to render them knowable and governable. As Andreas Hanses (2007) argues, such knowledges are a central characteristic of a profession.

### **Constitutional Elements of a Profession**

Further elements of a profession include a recognised body of theory, the necessity of training and qualification, the existence of a professional association and restrictions on entry to the relevant professional body (Cree, 1995). Adopting a rather medical understanding of professionalism, Hanses

(2007) suggests diagnosis, treatment and inference as the three substantial structural elements that mark professional practice.

Despite all these discourses around professionalism, what exactly constitutes a profession remains under dispute. While some sociologists argue that professionalisation should be thought of as a relative concept, placing different occupations along a continuum from non-professional to professional (e.g. Carr-Saunders, 1965), others take an absolute approach and argue that a certain occupation is either a profession or a non-profession (e.g. Wilensky, 1964).

### **Authority and Power**

Today, members of the tutelary complex, including medical doctors and social workers, are endorsed with legal power to define needs and to define the ways to address these needs (Illich, 1977). A medical doctor may thus identify the need of a child to concentrate at school, frame it under the label 'ADHD' and define pharmaceutical treatment to address that need in order to prevent associated risks. Illich argues that professional power is, consequently, essentially a 'specialised form of the privilege to prescribe' (1977, p. 17). The power of professionals, accordingly, relies on a society entitling certain occupations the right to prescribe, and the authority to define a person as a client. Professionals, consequently, depend on a social mandate and the political legitimisation of their body of knowledge (Hanses, 2007). It is the combination of such a mandate and a recognised body of knowledge that enables professions to define problems and ways to address them. Zola argues that, against this background, medicine has become a 'repository of truth', allowing doctors to present themselves as morally neutral and objective experts (1977, p. 41). However, he further argues that the apparent moral neutrality is the greatest potential for obfuscating moral issues.

While medicine is regarded as an established profession, other occupations in the health sector, including social work, are less likely to be regarded so. There have been significant efforts throughout the last few decades to make

social work more scientific by incorporating 'truths' from the 'psy' sciences, i.e. 'the human sciences, in particular psychology and its affiliates', (Rose, 1999, p. vii) in its body of knowledge. I will, though, elaborate on this in some more depth in the discussion chapter (cf. **Perspectives for Social Work**, p.281).

### **Inference**

As Hanses (2007) argues, professional practice has principally to deal with uncertainties. It is against this backdrop that the task of reaching a conclusion that is based on evidence and reasoning, termed inference, marks an important task of medics. Through inference uncertainties are addressed through specialist knowledge and the professional power to define adequate remedies for certain conditions. Uncertainty, through professional practice, is therefore being transformed into an expectable construction of certainty. An accurate level of certainty is, Hanses further argues, both expected by the patients and important for the political legitimisation of professional practice.

Against this backdrop, evidence-based medicine has more recently been promoted as a means to combine the best scientific evidence with practitioner expertise (Baker et al., 2009). It is in this context that guidelines on medical entities, including ADHD (see, inter alia, AAP, 2011; DGKJP et al., 2018a; NICE, 2009) take an increasingly important place in guiding the practice of doctors.

### **New Social Studies of Childhood**

The new social studies of childhood (see, for example Corsaro, 2011; James et al., 1998; McNamee, 2016; Qvortrup, 2005; Wells, 2017) is an interdisciplinary research field. It emerged as a response to the tendency within psychology and sociology to regard children merely as 'human becomings' (McNamee, 2016, p. 1) rather than human beings in their own right. Consequently, a core theoretical position of this interdisciplinary field is to acknowledge that childhood is a social construction, and that children are

social actors rather than passive objects of development and socialisation. Yet, at the same time, childhood is understood as being affected by institutions and structures. The relationship between structure and agency, thus, is a further central concern within this emerging body of research. Many investigations have been carried out to account for the diversity within contemporary constructions of childhood, including considerations of culture, gender, class, 'race', (dis)ability, spatiality and history. To account for the child as social actor, research within the new social studies of childhood tends to focus on participatory approaches, involving children at different levels in designing and carrying out research. This also reflects a shift in the conceptual understanding of children. Arguably, the way we conceptualise children along idealised images of childhood significantly shapes children's lived experiences. Let us consider these images.

### **Images of Childhood**

Chris Jenks (2005) suggests that throughout the cross-cultural and historical literature, two dominant traditions of conceptualising the child emerge. He refers to them as the Dionysian and the Apollonian images of childhood.

#### **The Dionysian Child**

The Dionysian image conceptualises children as potentially evil, headstrong and stubborn, but able to acquire innocence through disciplinary measures. In the light of this conceptualisation, socialisation of children was regarded as a form of combat. Consequently, parenting consisted of strict and distant moral guidance (*ibid.*). This harsh form of child-rearing was similarly reflected in the school setting, where the enforcement of strict discipline included various forms of corporal punishment (Foucault, 1989). This image, Jenks suggests, was dominant particularly during the time of Puritanism but persisted well into the twentieth century and informed 'the systematic secular exploration of the soul' (2005, p. 64) within traditions of psychoanalysis.

#### **The Apollonian Child**

The Apollonian image, on the other hand, emphasises the angelic, untainted and innocent nature of children. Viewed through the prism of this image,

Jenks (2005, p. 65) suggests, children 'are not curbed nor beaten into submission; they are encouraged, enabled and facilitated'. He further argues that this image resembles the modern way of viewing children, at least in the minority world. Both of these images, Jenks suggests, are immensely powerful in that they shape the discourses about children and childhood and summarise the way we have come to understand and treat children, particularly those considered 'deviant'. While such children were considered 'bad' by choice under the Dionysian image, more recent moves towards the Apollonian image tend to free children from moralising judgements regarding their behaviour. Consequently, 'deviant' children are regarded as innately good but affected in some way by a pathology that prevents them from displaying the behavioural patterns that societies in the minority world consider appropriate (although there certainly are social, political and cultural differences that I will discuss later in this chapter). This emphasis on pathology, however, arguably took away some of their autonomy and agency, and subjected them to treatment approaches aimed at rendering their behaviour docile. More recent discursive shifts against notions of advanced liberal subjectivity (Dean, 2010), though, suggest that children should be regarded as competent social actors who have rights of their own (Baraldi and Cockburn, 2018; Liebel, 2008, 2007).

### **The Athenian Child**

It is this focus on advanced liberal subjectivity that led Karen Smith (2012) to supplement (rather than supplant) the two images of the Dionysian and Apollonian child with the image of the Athenian child. This image emphasises the aim of advanced liberal rule to foster subjects that are able and willing to govern themselves. Smith argues that these qualities are sought to be fostered in children through strategies of responsabilisation and participation. She further suggests that while these images of childhood do not represent the totality of historical and contemporary constructions of childhood, they offer a useful framework to examine the entanglement of discursive constructions of childhood and relations of power such as class, gender and 'race' (ibid).

### **Homo Criminalis and Homo Economicus**

In a similar vein, Edward Comstock (2011) builds on the concepts of homo criminalis (where children are constructed through concepts of degeneration, deviancy and social hygiene) and homo economicus (where children are seen as advanced liberal subjects who aim to invest in themselves in the light of economic ideals). The common thread linking these images of childhood is the concern with the malleability of children, and how this may be employed to govern them towards specific ends. Of particular importance in this government are 'place, everyday spaces and spatial discourses' (Holloway and Valentine, 2000). The next section will briefly elaborate on the spatial dimension of childhood.

### **Childhood and the Concern with Spatiality**

The concern with spatiality is central to the new social studies of childhood. As a core theoretical assumption, it inspired what Nikitina-den Besten termed the 'geographical turn' (2009, p. 10), i.e. the increased interest in the spatial dimension of children's lives, and how children both negotiate and experience social spaces. Among these spaces the school plays a pivotal role, since children spend a significant part of their childhood in this setting. Indeed, scholars in childhood studies argue that the school and the home are the two single most important settings in children's lives in the minority world (McNamee, 2016; Rasmussen, 2004; Smith and Barker, 2001).

Yet, despite critiques of previous research (i.e. particularly of developmentalism), more recent sociological, historical and geographical enquiries still tend to be limited in accounting for the childhoods experienced around the globe. Indeed, much of the research available in the new social studies of childhood is both authored and situated in the minority world, and mostly built on the experiences and accounts of white, middle-class children (Wells, 2009).

### **Children's Use of Space**

Valentine and Holloway (2001) argue that adults generally tend to be concerned about children's autonomous use of space. Children are seen, again, as both at risk and being risky if they are not supervised.

### **Commercialised Play Spaces**

One response to these growing anxieties regarding children's access to and independent use of public space has been the development of institutionalised and commercialised play spaces (Smith and Barker, 2001). McKendrick et al. (1999) explored the diversity of such newer playgrounds, which range from small play zones in fast food chains to multi-level, indoor soft play centres. While all these facilities increase the range of available spaces designated for children, direct access to them is not enhanced, since the decision to use them is made more often by adults than by children. Additionally, low socio-economic background may prevent many families from accessing such spaces.

### **Out of School Clubs**

Another approach to keeping children under close supervision has been the establishment of out-of-school clubs. While they tend to be organised independently of the organisation of contemporary education, they operate at the boundary of home and school. In their research, Smith and Barker (2001) argue that the spatial environment, in this case the school, has significant implications for children's leisure time. While play is seen as one of the primary objectives of such clubs, children often found it difficult to make sense of the 'conceptual shift' of using the school for their leisure time rather than 'work' (ibid.). For example, children tended to refer to the club as school, and to their playworkers as teachers.

### **Virtual Spaces**

Recent technological advancements, including smartphones and the Internet, potentially provide children with new means to communicate, form friendships and create their own spaces. But there runs a certain contradiction throughout the discourse. On the one hand, children are



assumed to be equally, if not more, competent in using modern communication and information technologies. Children, through their competent use of these technologies, may therefore transcend traditional spatial boundaries and form a 'community of interest' online, which has been celebrated as empowerment (Cockburn, 2005, p. 330). On the other hand, these very competencies are rendered problematic in that they may put children at risk. McNamee (2016) argues that while children's use of the Internet for educational purposes is encouraged, using the same technology for leisure is problematised as risky behaviour and subjected to an ever increasing surveillance. The common theme running throughout the discourse, therefore, is the anxieties of adults regarding children being both at risk and risky when using space autonomously, be it virtual or physical space.

### **Childhood, Leisure and Culture**

As discussed throughout this chapter, contemporary minority world conceptualisations of childhood emphasise the importance of both the school and the family as appropriate spaces for children. A further core concern, then, is how, where and when children play. Borrowing from McNamee I prefer to use the term 'leisure' rather than 'play' to counterbalance the 'elitist view' that leisure is something in opposition to work, and consequently something that only adults possess or do (2016, p. 136). This approach acknowledges that what children do at school is work too, and that what we commonly refer to as 'play' is more than mere distraction. Furthermore, the term 'leisure' allows for the variety of activities children may engage in when not at work, including play, media use, reading books and so on.

Children's own perspectives on leisure have long been marginalised, and their activities have been described as naïve copies of adult culture (Montgomery, 2009). However, this position has been challenged by folklorists, including the ground-breaking work of Iona and Peter Opie (1997, 1969, 1959). The Opies argue that children have indeed their own culture, and that this culture is most visible in children's games, rhymes, songs and

jokes. Drawing on the accounts of more than 10,000 children playing in the street, in parks, in playgrounds and on wasteland, Iona and Peter Opie concluded that children are still engaged in leisure, despite the constraints that middle-class visions of childrearing bring along. Their work is a plea to give children both the time and physical space to live their own cultures in the company of other children. The conclusion by the Opies that children's traditional play, such as games and rhymes, remains an important part of childhood has been supported by the more recent work of Marsh and Bishop (2014).

Miller and Kuhaneck (2008) consulted children regarding their perceptions of play experiences and preferences. The choice of a specific activity was informed by several factors, such as the difficulty of the game, the physical activity it included, age and gender. All children in this study preferred to play with other children rather than with adults. This reflects that interactions between children and their peers tend to be characterised by autonomy and cooperation, while those with adults are marked by heteronomy and constraint.

Ennew (1994) argues that unstructured and unsupervised leisure is a site of contestation through which children resist the influence of adults. Children tend to hide what they do in their own time, referring to this as 'doing nothing' (ibid.) when asked by adults. In their own time children collectively experience the world around them, create and carry out rituals and games, and use their own language. All these elements are part of their own culture. As these are hidden from the adult world, Montandon argues, they may be regarded as distinct spaces, and as manifestations of children's autonomy (2001). Yet concerns regarding the safety of children in outdoor spaces increasingly keeps children in the private space of the family (Holt et al., 2015). It is to this social space that this review now turns.

## **Childhood and the Family**

This section briefly discusses the conceptualisation of the family, and how research on children has been and is being conducted with reference to and within the family.

### **Conceptualisation of the Family**

As Wastell and White suggest, 'the "perfect family" is arguably a core motif of contemporary utopian mythology' (2017, p. 8). In the minority world, though, the concept of 'family' draws on a rather narrow understanding that ideally includes the (biological) parents and their children only (cf. Kerber-Ganse, 2009). This conception of the normative white, middle-class 'nuclear family' (Leon, 2009, p. 7) has been promoted on a global level through its enshrinement into the United Nations Convention on the Rights of the Child (UN General Assembly, 1989). In Switzerland more recent debates have supported this particular understanding of the 'core cell of society' (Kraus, 2013, p. 213). Thus, children who are regularly cared for by family members, such as uncles, aunties and grandparents, are considered to be in extra-familial care (Brand, 2009; EJPD, 2011). However, the reality often looks quite different. Rather than in 'perfect families', children grow up in a variety of familial settings that are constituted and framed by events such as divorce, migration, disability and death (Wade and Smart, 2002). Such events may also have a significant effect on children and their lived experiences. Social adversity in families, such as lone parenthood, low maternal education, and reception of social welfare, is also linked with higher levels of medicalisation in children (Hjern et al., 2010).

### **Research on Children within the Family Context**

Even though the study of the family has a rather long tradition within sociology, children themselves have been rather marginalised, since they have been regarded as passive recipients of socialisation processes (McNamee, 2016). Only more recently have children's own accounts been given weight. The desire to account for children's agency, however, has potentially decontextualized children from familial settings (Wells, 2009).

Nevertheless, there is a growing body of children's own accounts of family life. Amongst the findings has emerged the recognition that, for most children, the quality of relationships seems to be of more importance than biological ties (Wade and Smart, 2002). In a study conducted in the canton of Geneva, children mentioned that they expect guidance and security as well as affection and support from their parents (Montandon, 2001). Generally, though, they feel more controlled than supported, and more supervised than listened to (ibid.).

## **Summary**

This section has focused on the wider discourses that ADHD is entangled with. The first part discussed what may be termed the 'rise of the social', i.e. how the introduction of compulsory schooling and the institutionalisation of public health allow us to observe, assess and chart the development of children. I argued that most of our taken-for-granted perceptions of how children develop are based on developmentalism, and that any deviance from the 'norm' is likely to be subjected to risk assessment and management. The discussion then went on to chart what has been termed the new social studies of childhood, an interdisciplinary field of research that aims to deconstruct contemporary understandings of childhood. I argued that a shift in images of childhood allowed the move away from regarding children as being 'bad'. Rather, children's behaviour is increasingly being pathologised, labelled and subjected to medical interventions. It is against this backdrop that the idea of ADHD gained popularity in contemporary discourse. The next section aims to indicate how ADHD has evolved as a distinct 'disease entity'.

## **Genealogising ADHD**

This section aims to draw a genealogical account of the emergence of ADHD. Genealogy is particularly interested in elaborating upon causative factors that drive the transition from one thought system to another (I elaborate on this term in more depth in the next chapter, see **Archaeology and Genealogy**, p.81). After tracing supposed flags of primordial ADHD the

discussion goes on to elaborate upon how the transition from psychoanalysis to pharmacology significantly shaped the discursive practices around ADHD. Finally, this section offers some discussion about how the construction of ADHD has been discursively established around claims of its impact, causality and prevalence.

## **Supposed Flags of Primordial ADHD**

In the light of mass education (see earlier in this chapter) and against shifting understandings of children showing ‘deviant behaviours’, the concern with short attention span and unrest in children in minority world medicine started centuries ago. In 1775 German physician Melchior Adam Weikard (1775) posited that overly distractible people should be separated from noise and any other sources of distraction. Yet the earliest extensive consideration of ‘inattention’ as a medical condition appears to belong to Alexander Crichton (Palmer and Finger, 2001). His work *An Inquiry into the Nature and Origin of Mental Derangement* constitutes ‘one of the first English texts to systematically delineate what we now call psychiatry’ (Schwarz, 2016, p. 15). Crichton devoted a whole chapter to the phenomenon of attention and its related diseases. However, he also cautioned that while having a pathological character in adults, distractibility in a child was normal. Every child, Crichton suggested, has a different ‘mental diet’ that helps them to cultivate attention: ‘many boys require very different objects of study than what others do, in order to have their attention sufficiently roused, and their minds put into due exercise’ (Crichton, 1798, p. 277ff). In 1845 German physician and psychiatrist Heinrich Hoffmann published the book *Struwwelpeter* (1845) containing stories, including one called *Zappelphilipp* [Fidgety Philipp], a boy who can’t sit still at the dining table. 150 years later ADHD advocates began to interpret these stories as proof that the condition had been recognised for some time. In 1902, Sir George Frederic Still, a pioneer in the field of paediatrics, gave a seminal lecture before the Royal College of Physicians in London called *On Some Abnormal Physical Conditions In Children*. Still described children who had what he called a

‘defect in moral control’, demonstrating a ‘quite abnormal incapacity for sustained attention’ (1902, p. 48). What was genuinely ground-breaking in his work was his observation that while such behaviour might appear in children who had a history of brain injury, other children had no physical cause for their behaviour. Still suggested that, rather than emanating from a bad upbringing or from conscious choices, these children’s hyperactivity and impulsivity must stem from some unexplained processes in their brains. Three decades later, in an influential account, Bradley (1937) reported on the effects of exposing children with behavioural problems to Benzedrine Sulfate. The week-long study observed ‘a spectacular improvement in school performance in half of the children’. Moreover,

[a] large proportion of the patients became emotionally subdued without, however, losing interest in their surroundings (Bradley, 1937, p. 577)

This serendipitous finding laid the ground for an important shift in psychiatric discourse: the shift away from psychoanalytic towards pharmaceutical interventions.

## **The Shift from Psychoanalysis to Pharmacology**

Up to the middle of the 20<sup>th</sup> century psychiatry was predominantly psychoanalytic in orientation (Eisenberg and Guttmacher, 2010). Psychoanalysis taught medical students to engage with their patients in an empathic way, and they were asked to try to understand their patient’s source of distress rather than simply classify them. Psychoanalysis, therefore, was inherently concerned with the individuality of its patients. In the absence of an alternative to the comprehensive psychological theory explaining the origins of psychopathology, and given that the brain sciences were largely irrelevant to clinical practice at that time, psychoanalysis was the predominant approach to dealing with mental health issues (ibid.). However, through a series of discoveries of pharmacological drugs that were thought to be relatively syndrome-specific, standardised assessment became more important, paving the way to superseding non-drug approaches (Timimi, 2009a, p. 147).

Eisenberg and Guttmacher describe this phenomenon as the shift ‘from mind to brain’, leading to clinical practice that seems to ignore the accounts and life stories of patients (2010, p. 93). Growing prescription rates of psychotropic substances, consequently, owe much to the decisions to opt for drug treatment instead of psychotherapy to address mental health and behavioural issues in children (Abraham, 2010). Support for this argument may be found in countries like France, Italy and Brazil that resist this move to biological reductionism. In these countries prescription rates for psychotropic drugs remain low as ‘clinicians tend to perceive ADHD as a psycho-affective disorder and favour psycho-social interventions’ over drugs to treat children (Conrad and Bergey, 2014, p. 34). The focus lies on elucidating the meaning of symptoms and their connections to the environmental circumstances that affect children’s behaviour and wellbeing. Nevertheless, in many countries of the minority world, the medical model of ADHD has been well received.

Offering a ‘label of forgiveness’ (Reid and Maag, 1997) by attributing troubling behaviour to neurobiological forces outside an individual’s control, it is understandable that contemporary psychology and psychiatry were received well by many parents. It is in this context that psychotropic drugs became an obvious solution to amend ‘deviant behaviour’ in children, as they were no longer seen as ‘bad’, but rather as ‘ill’ (I will discuss this in more depth in Chapter Six, cf. **From Mother Blaming to Forced Screening and Drugging**, p.235). Former disciplinary measures, such as corporal punishment, segregation and imprisonment, increasingly diminished in favour of pharmaceutical interventions.

## **Moving Towards a Diagnosis Called ADHD**

Hyperactivity and poor attention span were then linked under the umbrella of a diagnosis of minimal brain damage (Timimi and Leo, 2009). Lehtinen and Strauss (1947) suggested that the absence of an abnormal family history was sufficient evidence for biological brain damage, but given that it was a minimal damage, identification was difficult. However, in the 1960s, the diagnosis of minimal brain damage was abandoned, since no underlying

organic lesions could be found. As part of a growing interest in behaviourally defined syndromes, the focus of the second edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1968, hereafter DSM-II) was now on the behaviour of children rather than on their individual biology. The new diagnosis was called Hyperkinetic Reaction of Childhood and gained significant interest in child psychiatric practice and research. With the introduction of DSM-III (APA, 1980), the condition was now termed Attention Deficit Disorder (ADD). This encompassed the three dimensions of 'attention deficit', 'hyperactivity' and 'impulsivity', and the diagnosis could now be made as ADD both with and without hyperactivity. The DSM-III-R (APA, 1987) abandoned the idea of these three dimensions and combined all symptoms into one dimension. The new terminology was now Attention Deficit Hyperactivity Disorder (ADHD), assuming that hyperactivity, inattention and impulsivity all formed part of the same phenomenon. In 1994 the DSM-IV (APA, 1994) reconsidered the diagnosis and proposed a model that incorporated two subcategories, namely attention deficit and hyperactivity/impulsivity. In addition, if there were children displaying certain symptoms in one of these sub-dimensions that did not meet the full criteria, then the diagnosis 'ADHD not otherwise specified' should be made (ibid, p.85). The diagnosis, thus, became increasingly inclusive. As Timimi and Leo argue,

[i]f we were to interpret this concretely (as doctors often do) it suggests that, as of DSM-IV, nearly all children (particularly boys) at some time in their lives could meet one of the definitions and warrant a diagnosis of ADHD (Timimi and Leo, 2009, p. 3)

A similar critique has been raised regarding the latest edition of the American diagnostic handbook DSM-5 (Frances, 2013). Arguably, DSM-5 may be even more inclusive in the wake of changes to diagnostic criteria. For example, the threshold of symptoms has been lowered for older adolescents, and comorbid diagnoses with autism spectrum disorder are now allowed (Raines, 2014).



## **Impact**

Proponents of ADHD describe the disorder as seriously affecting the well-being of children. Social isolation, accidents and long term psychological distress are amongst the most cited negative impacts (Tannock, 1998). Children with undiagnosed ADHD appear to be often dismissed as antisocial, disorganised and lazy (Cooper, 2001). Their school performance is believed to be far lower than their intellectual ability would predict (Hinshaw, 1993). Furthermore, ADHD is believed to be highly comorbid with other psychiatric diagnoses (Biederman, 2005). In the long term, ADHD is being associated with several negative outcomes, including substance abuse (Greene et al., 1997), higher rates of depression (Able et al., 2007), suicide (Singer, 2006), relationship problems (Hinshaw, 1993), employment difficulties (Barkley, 2014) and imprisonment (Weiss and Hechtman, 1993).

## **Causes**

ADHD has become one of the most widely researched phenomena in childhood, but its precise cause(s) remain(s) elusive (Cooper, 2001). Tannock (1998) suggests that there are three main areas of theoretical exploration within international medical enquiries into the causes of ADHD: cognitive, neurological and genetic research. The cognitive research strand has increasingly focused on the theory that problems with inhibiting or delaying a behavioural response lead to higher levels of impulsiveness, which, in turn, negatively affect the so-called executive functions. They include working memory, internalised speech, motivational appraisal and the ability to deconstruct and analyse past experiences relevant to a current situation (Barkley, 2014). These difficulties with executive functions become visible in environments where there is strong emphasis on sedentary behaviour, particularly in school settings (Lloyd et al., 2006a). Neuroimaging research has indicated similarities between core symptoms of ADHD and behaviours exhibited in the context of brain injuries, particularly in relation to the prefrontal cortex region of the brain (Hinshaw, 1993). Moreover, genetic research has pointed to some genetic abnormalities in the dopamine system (Levy and Hay, 2001). Although it is generally agreed that genes do not

predict behaviour (Howe, 2010), predispositions in interaction with the environment may lead to certain behavioural outcomes (Cooper, 2001). While it is rather difficult to control for environmental influences in the study of the development of behavioural outcomes, twin and adoption research claims that the heredity argument is valid (Castellanos et al., 2003). As Wastell and White (2017, p. 66) suggest, though, of more fundamental importance than the 'equal environments assumption' is a limitation built into the design of these studies:

[i]n order to isolate the effect of genes, the twin study necessarily seeks to eliminate any differential environmental influences, or 'confounds' as they are known in scientific argot. But in doing so, it becomes intrinsically impossible to measure the relative strength of the genetic effect compared to the influence of the environment (ibid., p.66ff)

Against such a study design the effects of, for example, class, 'race', culture and socio-economic status could not be shown by such twin studies,

simply because the common environment assumption entails that only twins living in the *same circumstances* can be compared (ibid., p.67, emphasis in original)

In support of this critique, more recent research in epi- and molecular genetics challenges the heredity argument and suggests that genes are not specific to ADHD (Gao et al., 2014; Li et al., 2014; Thapar, 2018).

## **Prevalence**

The prevalence rate of ADHD varies in epidemiological studies around the globe, ranging from 1 to 17.8 per cent (Conrad and Bergey, 2014). Pooled prevalence data shows substantial differences regarding demographic characteristics and geographic locations (Polanczyk et al., 2007). Significantly lower prevalence rates have been found in girls than in boys, and higher rates have been found in children than in adults. The largest range of prevalence rates has been found in Africa, while those studies claiming the highest rates are found in South America. Some explanations regarding these differences include the use of different definitions of the condition (Faraone et al., 2003) and variation in the methodology of the

research (Polanczyk et al., 2007, 2014). With each revision of the DSM the prevalence rate of ADHD has increased significantly (Kean, 2009). Prevalence rates of medical interventions are usually based on the use of stimulant drugs. However, this may significantly underestimate the actual treatment practice of ADHD, as other prescribed medications potentially include clonidine, antidepressants, neuroleptics and selective serotonin reuptake inhibitors (ibid.).

## **Summary**

This section has elaborated upon the supposed flags of primordial ADHD and has argued that, in the wake of the introduction of compulsory schooling and shifting conceptualisations of childhood, the concern with short attention span and unrest in children started back in the 18<sup>th</sup> century. It has then elaborated on how discursive practices around ADHD were significantly shaped by the shift from psychoanalysis to pharmacology in psychiatry. To conclude, some elaborations on claims to impact, causes and prevalence regarding ADHD have been offered. These claims have laid the ground for the popularisation of ADHD, which is the focus of the next section.

## **Popularising ADHD**

This section elaborates on the central drivers of the ADHD phenomenon, including the role of biomedicalism, medicalisation, advocacy groups, the pharmaceutical industry and deregulatory policies. The review then turns its focus to the voice of 'experts' in medicine through examining the core messages in the debate around ADHD, and how these are circulated through professional networks.

## **Central Drivers of the ADHD Phenomenon**

Sociologist John Abraham offers the concept of pharmaceuticalisation to explain the phenomenon of prescribing pharmaceuticals to an ever-growing population of children. He defines pharmaceuticalisation as

the process by which social, behavioural or bodily conditions are treated or deemed to be in need of treatment, with medical drugs (2009, p. 934).

This includes the traditional concept of medicalisation, but also expands on it to account for other significant explanatory factors of contemporary health phenomena: (i) biomedicalism, (ii) industry drug promotion and marketing, (iii) consumerism and (iv) ideology or policy of the regulatory state. Similar drivers have been identified regarding the globalisation of American psychiatric diagnoses in general (Watters, 2010), and the globalisation of ADHD specifically (Conrad and Bergey, 2014). In addition, the role of mass media (Horton-Salway, 2018) and the Internet (Conrad and Bergey, 2014) have been identified as significantly driving the popularisation of ADHD. Let us consider these in turn.

### **Biomedicalism**

The biomedicalism thesis claims that growth in drug treatment reflects advances in biomedical sciences to meet advanced health needs (Abraham, 2010). It is argued that the progressive capacity of biomedical science leads to the discovery of pharmaceutical solutions for both new and established health conditions. Proponents of the biomedicalism thesis claim that the expansion of ADHD and the growing pharmaceuticalisation reflect advancements in science and allow children who were previously untreated to receive the medication that they need. ADHD has, in this view, been rationalised as a valid organic brain dysfunction caused by dopamine deficiency and treatable with pharmaceutical intervention (Barkley, 1998). However, as Abraham (2010) argues, consumerism, together with industry promotion, medicalisation and deregulatory state policies, are more convincing explanations for the phenomenon of an increasing tendency to treat children with pharmaceuticals than is biomedicalism.

### **Medicalisation**

Medicalisation refers to the phenomenon of defining or describing social deviance in medical terms, attributing a medical cause to it, and proposing medical solutions such as hospitalisation, psychotherapy and pharmaceutical

interventions (Conrad and Schneider, 1992). An important driver for medicalisation is the incentives that medical diagnoses may bring along. Teachers face fewer obstacles in attracting funding if children have medical diagnoses, and disadvantaged families may receive financial support and gain access to advanced health services (Lloyd, 2006). As Timimi notes, ADHD is a case example of how a scientific paradigm 'has the capacity to construct new realities and whole new ways of thinking' (2009a, p. 145). The medical profession holds a rather powerful position in contemporary minority world societies, and through popularising the concept of ADHD, people's (including parents, teachers, social workers, health practitioners etc.) consciousness is being shaped in a way to make them concerned about children's 'ADHD behaviours' (ibid., p.135). Yet, although the sociological concept of medicalisation has been advanced recently to account for shifting power relations away from the medical profession to the pharmaceutical industry, it does not cope well with the huge amplification of prescriptions for stimulant drugs to children in the context of ADHD (Abraham, 2010). While some of these prescriptions may have resulted as an effect of increased diagnosis and medicalisation, decisions to opt for pharmaceuticals instead of psychotherapy to address emotional and behavioural problems may be of even more significance (ibid.).

### **Consumerism and Advocacy Groups**

Collective consumerism activities have significant impacts on pharmaceuticalisation, for example through lobbying for the (re-)introduction of psychotropic drugs into the market (Conrad and Bergey, 2014) or by influencing regulatory bodies to lower the thresholds in drug regulations (Abraham, 2010). The power of advocacy groups, which are increasingly funded by the pharmaceutical industry (Conrad and Bergey, 2014), has been described as being an important driver of the proliferation of the concept of ADHD (Bonati, 2006).

Furthermore, consumerism has an ideological dimension, which reveals itself in

the discursive appropriation of the health needs of patients as the demands of consumers in a market (Abraham, 2010, p. 612)

These discourses suggest that the 'informed patient' or 'expert patient' is sufficiently knowledgeable regarding advertising claims about prescription drugs (Abraham, 2010, p. 612). The availability of diagnostic questionnaires on the Internet (Conrad and Bergey, 2014) empowers patients (and, in this case, parents) to self-diagnose themselves (or their children), while the doctor's role is being shifted to becoming a 'gatekeeper' (Abraham, 2010, p. 612). The expertise that the hegemonic discourse seeks to foster in the 'expert patient', though, is not neutral but highlights the superiority of pharmaceuticals (Britten, 2008). While there are also advocacy groups arguing against drug treatment, they are part of the 'counter-discourse' (Jäger and Maier, 2010, p. 50) and are therefore being marginalised.

In Switzerland the parent advocacy group Elpos is well known for its awareness-raising campaigns. Its name is made up of two constitutive parts: 'Eltern' (meaning 'parents') and 'POS' (the abbreviation for Psycho Organic Syndrome, hereafter POS). The history of the parent advocacy association is well documented by Fredi Ehrat (1994). In the summer of 1973 two articles were published in the newspaper Tagesanzeiger, introducing the idea of POS to a public audience for the first time. Ehrat argues that these articles were well received by parents of children who seemed to have the described syndrome. In early 1974 the association Elpos was founded with 50 members. Ehrat claims that while the problem had been known abroad for several years, in Switzerland medical doctors had been reluctant to adopt the concept. The founding members argued that because of the lack of educational measures and parent counselling, children were distressed during their time at school, would face a variety of difficulties during their adolescence, and would finally end up with a broken adult life. Against this backdrop parents experienced negativity from others:

[f]or the parents it meant reproaches for wrong upbringing, unending worries and finally feelings of guilt (Ehrat, 1994, p. 21).

In response to this Elpos became active on different platforms. Its objective was to inform the public, authorities, professionals and teachers about the idea and nature of POS. Moreover, its aim was to build a school system that was suitable for children labelled with 'POS'. Its activities included presentations, family picnics, craft afternoons and the like. It is remarkable that its first publication refers to the 'scientific fact' (Fleck, 1979, p. 23ff) that 5 percent of all children have a minor brain dysfunction. I will, however, elaborate upon this in some more depth in Chapter Four, see **Epidemiology and Prevalence Rates**, p.117). Within a few years Elpos was well established as the parental organisation of children labelled with POS. In 1976 its first conference took place and was widely recognised in the media. 31 newspapers reported on the event, including the Neue Zürcher Zeitung and the Tagesanzeiger (Ehret, 1994). In 1995 Elpos aligned its organisational structure with the requirements of the Swiss Federal Social Insurance Office in order to receive funding from this governmental body (Elpos, n.d.). More recently Elpos refers to itself as ADHD Organisation to account for the shift in the use of terms, i.e. a move away from POS towards ADHD.

### **Pharmaceutical Industry**

The pharmaceutical industry has become the second largest in the US, just behind the arms industry (Timimi, 2009a). Over the last few decades it has significantly grown in profitability and strength, which has put it in a position to control research agendas and to employ influential marketing strategies (ibid.). Research has indicated that these marketing practices significantly shape prescribing habits (Wazana, 2000). The content of advertisements, though, lacks support from the scientific literature in many cases (Leo and Lacasse, 2009, p. 308). Direct-to-consumer advertisement (DTCA) for prescription drugs has been described as a central explanation for growing medicalisation, but this only applies within the context of the US and in New Zealand, as in every other country DTCA has been prohibited. Involving senior medical professions in marketing strategies allows pharmaceutical companies to present their medication in a favourable manner, leading to

bias in medical literature and supporting the popularisation of ADHD (Abraham, 2010).

### **Deregulatory Policies**

The ideology of the regulatory state significantly shapes prescription patterns. In the US deregulatory policies allowed the pharmaceutical industry to put drugs on the market that 'offer little or no therapeutic advance in a sea of declining innovation' (Abraham, 2010, p. 615). Additionally, research suggests that the approval and promotion of slow release amphetamines like Methylphenidate led to significant increases in ADHD diagnoses and treatment (Conrad and Bergey, 2014).

### **Mass Media and the Internet**

Horton-Salway (2018) suggests that both lay and professional discourses are influenced by media representations of ADHD. The way the public is likely to interpret the meaning of this phenomenon is, she further argues, shaped by both the forms of language used and the media framing (i.e. the perspective or angle from which news stories are being told). While ADHD has commonly been framed as a polarised discourse in terms of its causes, either highlighting its biomedical or psychosocial nature in a reductionist manner (ibid.), more recent articles increasingly base themselves on more complex representations (Ponnou and Gonon, 2017). Through 'mediating information about ADHD' (Lloyd and Norris, 1999, p. 506), the media play an important role in implementing political agendas, which is likely to influence 'which stories get told and which are suppressed' (Seale, 2003, p. 514). An important means of telling these stories is the use of stereotypical images (see, inter alia, Sternadori, 2014), such as the neurologically impaired child or the environmentally stressed child (Schmitz et al., 2003). While these representations vary across cultures and change over time, in the minority world, in the wake of biological determinism,

representations of ADHD as a neurological impairment depicting children as abnormal and in need of medicalised solutions are common and such accounts are often dependent on reports of new science findings on ADHD evidenced by brain scan or gene research (Horton-Salway, 2018, p. 77)



However, such references to scientific findings are not neutral but rather 'inherently ideological' (ibid., p.73), and often depicted as 'a grand unveiling of indisputable truth' (Harwood et al., 2017, p. 5). Furthermore, discrepancies between 'weak or controversial findings' and the 'established conclusions' presented in the media are rather common (Gonon et al., 2011, p. 1). In addition, while medication is frequently promoted as standard treatment in ADHD, there are 'concerns about exaggerated claims of benefits' in media coverage, while harms simultaneously are inadequately covered (Robertson et al., 2013, p. 2). Moreover, Ray and Hinnant argue that media articles function to normalise pharmaceutical interventions in ADHD through the use of metaphors such 'as diabetics taking insulin or people with poor sight wearing glasses' (2009, p. 11). Generally, ADHD is being presented on the media plane as a threat by transporting a 'worrying number of negative identities for children' (Horton-Salway, 2018, p. 92).

While print media see declining subscription rates (Pew Research Center, 2019), the Internet is of growing importance in the circulation of knowledges around ADHD (Horton-Salway, 2018). Parent support groups such as Elpos provide access to a variety of information, including 'self-diagnostic checklists along with advice about seeking medical or educational help' (ibid., p.82). The most prominent Internet presence, however, is held by medical websites that promote a medical understanding of ADHD and its treatment (Foroughani, 2008). Such websites often provide tools that aim to facilitate a 'do-it-yourself diagnosis' and, in turn, popularise diagnostic criteria that are set out in the DSM (Conrad and Bergey, 2014, p. 39).

While the hegemonic discourse aims to popularise the idea of ADHD as a disorder in need of medical treatment, there are also instances of counter-discourse (Jäger and Maier, 2010) running throughout the media. Such accounts are often voiced by parents in defence of their children as a means of resisting negative stereotypes (Horton-Salway, 2018) and may be understood as 'creative acts of resistance' through which positive and affirming identities are sought (Rodriguez, 2010, p. 3). Other accounts seek

to offer 'valorised representations' by portraying children labelled with ADHD as heroes, such as the fictional character Percy Jackson, in whom 'ADHD is constructed as an asset rather than a deficit' (Horton-Salway, 2018, p. 90). In addition, positive accounts around 'high flying public figures, mostly male, such as Winston Churchill' aim to link ADHD to success and 'invit[e] the public to imagine the loss to the nation if highfliers are subdued by medication' (ibid., p.90). Horton-Salway, though, suggests that such accounts are not necessarily empowering, since they are 'constrained by cultural and gendered stereotypes and moral imperatives' (ibid., p.91). While health professionals appear frequently on the media regarding ADHD (Ponnou and Gonon, 2017), the voices of children appear to be 'conspicuously absent' (Harwood et al., 2017, p. 6).

### **The Voice of 'Experts' in Medicine**

In the promotion of ADHD as a 'valid disorder' medical experts are a vital part of the dominant discourse and limit what is sayable (Jäger and Maier, 2010). These limiting characteristics reveal themselves in texts authored by 'key opinion leaders', such as the *International Consensus Statement on ADHD* (Barkley, 2002). In this statement, 'an independent consortium of leading scientists' depicts ADHD as a valid disorder that involves 'a serious deficiency in a set of psychological abilities', and which is highly inheritable, with a genetic contribution between 70 and 95 per cent (2002, p. 89). The statement highlights that although ADHD is sometimes depicted as a controversial phenomenon in the media, '[i]n fact, there is no such disagreement', degrading opposing voices to '[t]he views of a handful of nonexpert doctors' and the 'propaganda of some social critics and fringe doctors' (ibid., p.89). Among 'the world's leading clinical researchers', the statement further claims, ADHD is being recognised as a valid disorder, 'regardless of culture' (ibid., p.89). The statement concludes that ADHD has

varied and substantial adverse impact on those who may suffer from it through no fault of their own or their parents and teachers (ibid., p.91).

In a similar vein, the *Global Consensus on ADHD/HKD* (Remschmidt, 2005, p. 127) 'aims to re-affirm that ADHD is valid disorder that exists across different cultures' and is in need of pharmaceutical treatment. The medical expertise in such statements is not neutral but reflects the success of the pharmaceutical industry in building 'key opinion leaders' in order to shape the discourse around ADHD (Jackson, 2009; Moynihan, 2008; Rose, 2019).

ADHD, thus, 'creates a professional discourse' (Norris and Lloyd, 2000), excluding both lay people and other professionals and elevating the status of some experts (Lloyd et al., 2006b). Some scholars even argue that this discourse has led to 'a new category of childhood', namely 'that of the ADHD child' (Timimi and Leo, 2009, p. 1). The power and control of experts may lead to the marginalisation of parents and children themselves (Muthukrishna, 2006), and potentially creates instances of disempowerment, pessimism and discouragement about the possibility of effecting change in people challenging the hegemonic discourse (Cohen, 2006b). These processes of exclusion are supported through highly technical vocabulary, such as 'neuro-developmental disorder'. Such terminology not only obscures meaning but also empowers 'those that know' (Newnes, 2009, p. 161), and elevates the status of medical professionals to 'experts on child rearing' (Sobo, 2009, p. 378).

Given the hegemonic character of the discourse that depicts ADHD as an uncontroversial, given truth (Tait, 2006), professionals who challenge these notions often find themselves ignored and insulted (Newnes, 2009, p. 163). Such denunciation forms an important part of marginalising opposing positions in discourses (Jäger and Maier, 2010). Kean (2009) has explored the promotion of the concept of ADHD in Australia. He problematises the way medical experts have received significant financial benefits to promote a biological/neurological basis for the disorder. This, he suggests, does raise questions concerning the construction of knowledge around ADHD.

## **Core Messages in the ADHD Debate**

As Kean (2009) argues, in order to promote ADHD and stimulant treatment, the risks of the relevant drugs are being presented as minimal. Particularly, Methylphenidate is popularised through presenting it as 'an extremely safe medication, being non-addictive, with only mild side effects for the majority of users' (Cooper, 2001, p. 392). Such claims contradict the fact that psychostimulant drugs are classified as controlled substances. Yet the American College of Neuropsychopharmacology declared that the use of stimulants is dangerous only for 'normal' children, not for children with 'ADHD' (Leo and Lacasse, 2015). Generally, dominant medical discourse aims to undermine any critical assessment of stimulant use in children:

[a]ny professional who disputes the benefits of stimulant medication in ADD is very out of touch with the modern research literature... this form of therapy is so well proven it is no longer worth our debating this point. Some people still believe the earth is flat, but that's not our problem (Green and Chee, 1994, p. 50)

Challenging this position, Jackson argues that the 'disruptive effects of stimulants upon development and growth' have been demonstrated through research findings over a period of more than four decades now (2009, p. 256). However, through 'privileged and redundant publications of studies', opinion leaders have successfully shaped the discourse on prescription drugs to present them as being safe (ibid., p.256). 'Redundancy' in this context refers to the phenomenon of publishing a great number of articles that do not add to the existing knowledge but serve to promote the superiority and safety of drugs. Such redundant publications are a common means of shaping discourses (Jäger and Maier, 2010), leading to 'journalistic obfuscation' (Jackson, 2009, p. 257). An important part of the discourse on the benefits of stimulant therapy is the argument that it may prevent future cocaine or amphetamine dependence (Barkley et al., 2003; Biederman et al., 1999). However, this assumption is far from being undisputed (Lambert and Hartsough, 1998).

The Multimodal Treatment Approach (MTA) study (MTA Cooperative Group, 1999) is of particular importance in the discourse on ADHD as my analysis suggests that it designates a 'discursive event' (Jäger and Maier, 2010). Discursive events refer to the phenomenon of influencing the development of a discourse through the intensive use of politics and the media. Whether an event becomes a discursive event or not consequently depends on the power relations at work (I discuss this term in relation to other discourse analysis terminology in Chapter Three, see **The Structure of Discourses**, p.98). Arguably, the publication of the MTA study had a significant impact on the further development of the ADHD diagnostic and treatment practice, particularly regarding the use of methylphenidate as the 'gold standard' of therapy. This has been achieved through portraying Methylphenidate as superior to any other approach. Although both MTA follow up studies at three years (Jensen et al., 2007) and eight years (Molina et al., 2009) found no significant benefit in the use of Methylphenidate, but many adverse effects, Methylphenidate remains the predominant treatment for ADHD. Ignoring the findings of the two follow-up studies, the consensus paper led by Remschmidt (2005) mentions the initial MTA study as the only treatment study, even though it is now largely discredited in the literature (Timimi and Maitra, 2009). In the context of Switzerland, the Swiss Society for ADHD (hereafter Society) has arguably become an authoritative voice in the dissemination of these core messages around ADHD. Let us briefly consider this organisation.

### **The Swiss Society for ADHD**

Founded in 2005, the Society endeavours to create a platform and network for 'medical doctors, psychologists and other professions who deal intensively with ADHD' (SFG ADHS, 2018a). It further

aims to inform the general public about all aspects of ADHD, based on scientifically sound knowledge from ongoing research and clinical practice (ibid.)

While Elpos is representing lay people, i.e. foremost, parents of children labelled with 'ADHD', the Society represents the professional voice in the discourse. It is funded by several pharmaceutical companies that produce and/or distribute drugs to treat ADHD, including Medice, Janssen and OpoPharma (SFG ADHS, 2018b). In its information sheet the Society depicts ADHD as a 'mainly genetically determined, neurobiologically explainable' entity, and proposes medical treatment approaches with detailed reference to a number of drugs, including Concerta, Medikinet MR, Ritalin LA, Equasym XL, Focalin XR, Strattera and Elvanse (SFG ADHS, 2016a, p. 1ff). The last page of the three page document informs the reader about DSM-5 criteria and concludes that ADHD is a 'lifelong condition' (ibid, p.3).

## **Summary**

This section has focused on how the concept of ADHD has been and keeps being popularised, by identifying a number of central drivers, including medicalisation, advocacy groups, the pharmaceutical industry and deregulatory policies. I argued that the knowledges transported by the hegemonic discourse are not neutral but tend to highlight the superiority of pharmaceuticals in the treatment of ADHD. I have further suggested that this reflects the success of certain actors, particularly the pharmaceutical industry and key opinion leaders, in constructing an image of ADHD around biological and neurological understandings. The discussion then went on to elaborate upon the core messages in the discourse around ADHD. I have argued that the so called Multi Treatment Approach Study may be regarded as a discursive event since it established the idea that pharmaceuticals are not only safe but constitute the gold standard of treatment. I further argued that institutions, such as the Swiss Society for ADHD, play an important role in disseminating knowledges around ADHD. Yet these discursive practices also invite opposition. It is this 'counter-discourse' (Jäger and Maier, 2010) that the review now turns to.

## Problematizing ADHD

The construction of ADHD as a category of difference is part of the wider medicalization of psychiatry and mental health. Further increasingly popular concepts that tend to medicalise what might partly be social problems include depression (Jadhav, 1996), post-traumatic stress disorder (Kienzler, 2008; Young, 1997) and autism (Milton, 2014). Critics of such concepts have challenged their emphasis on the biological basis of mental health issues, their claim that shared biology leads to universality in experiences across cultures, and their focus on proposing individualistic solutions (Clark, 2014). The hegemonic discourse treats ADHD as an 'objective truth' (Tait, 2006). However, this thesis draws on Foucault (1989) in order to suggest that the introduction of new 'disorders' may be best understood in the light of a modern art of governance. As Tait suggests,

by the sub-division of the population onto an exponentially increasing number of categories, it becomes possible to regulate conduct to an ever-finer degree (2006, p. 84)

This modern art of government (I discuss this in some more depth in Chapter Three, see **Analytic Strategies**, p.100) is concerned with regulating conduct towards specific ends, targeting both the body (Foucault, 1989) as well as the mind (Rose, 2007). Over the past three decades the number of categories of 'childhood difference' (Tait, 2006) has grown to more than 300, offering distinctive intervention strategies as a means of governing children. The 'psy disciplines', i.e. 'those fields of knowledge associated with mind, mental life, and behavior' (McAvoy, 2014, p. 1527), foremost psychology and psychiatry, are therefore engaged in an 'ongoing and accelerating process of *creating* difference' (Tait, 2006, p. 93, emphasis in original) rather than offering inclusion in classrooms through means of pedagogical strategies (Hjörne, 2006).

The next three sections aim to build on this critique by problematising medicalised practices and through offering some alternative perspectives to the hegemonic discourse.

## **Medical Practice**

As described above, leading experts depict ADHD as ‘a real disorder’ (Barkley, 1995, p. 17). There are, though, counterclaims that completely deny the existence of ADHD (Baughman and Hovey, 2006; Saul, 2014). Alternative explanations to the brain-disorder theory have been offered from a wide range of disciplines. Let us consider some of these.

## **Critique of Medical Research**

Generally, the research evidence for a neurological basis for ADHD appears to be ‘far from conclusive, or even inconsistent at times’ (Cooper, 2001, p. 389). Treatment studies have been critiqued for both low quality and for the focus on short term effects only. In their meta-analysis on the effects of Methylphenidate, Storebø et al. (2015) found that the quality of the evidence that highlighted the positive effects of this psychotropic drug was very low. They concluded that given these significant weaknesses, and given the lack of long-term studies, it is not possible to say whether prescribing Methylphenidate will have a positive impact on the lives of children labelled with ADHD. These conclusions support findings of earlier meta-analyses (Schachar et al., 2002; Schachter et al., 2001).

As Cohen (2005) argues, the use of various methods to censor and suppress negative findings on the use of Methylphenidate in children has led to a publication bias, presenting the drug as more evidence-based than it actually is. Medical research, by focusing on the areas where children labelled as ADHD perform poorly, tends to ignore the many abilities of these children. Through normalising processes and an ever-narrower understanding of ‘normal’ behaviours and abilities, children who are very imaginative and creative but show some weaknesses in verbal learning, are being marginalised and rendered problematic (Mercogliano, 2009). As Double (2019, p. 62) suggests, psychiatric research ‘has become too focused on speculative neurobiological notions’. More broadly, Timimi (2009b, p. 142) proposes that ‘the idea that ADHD is a medical disease shapes how the research is then conducted’, which in turn leads to discovering that children



labelled with this 'disorder' are sub-standard. The major emphasis of the ever-greater publication rate around ADHD has been on studies demonstrating the efficacy of medication as opposed to other forms of treatment and towards uncovering differences in the structure of brains (Hart and Benassaya, 2009).

### **Critique of the DSM**

The number of childhood disorders in the DSM has increased from 106 in 1952 (DSM-I) to 357 in 1994 (DSM-IV, with no increase in diagnoses in DSM-5 in 2013), and diagnostic criteria have been consistently widened (Abraham, 2010). The eighteen behavioural signs as outlined in the DSM have been criticised for describing normal childhood behaviour (Conrad and Schneider, 1992), and 'large-scale epidemiological studies found that nearly 50 per cent of children satisfied ADHD symptom criteria' (Abraham, 2010, p. 608). An ADHD diagnosis accordingly represents primarily the perceptions of parents and teachers in the form of ratings. Yet the use of rating scales is highly subjective (Barnes et al., 2003). DSM is much more inclusive than the International Statistical Classification of Diseases and Related Health Problems (ICD) provided by the World Health Organisation (2019, 1994), and it has been argued that the DSM has set the boundary of normality regarding brain function too narrowly (Abraham, 2010; Carey, 2002; Conrad and Schneider, 1992; Frances, 2013; Mercogliano, 2009).

### **Critique of Psychiatry**

In response to concerns regarding psychiatric practice, a body of critical literature emerged that is often framed under the term 'anti-psychiatry' and is particularly associated with psychiatrists Thomas Szasz and R. D. Laing, although both rejected this designation (Double, 2019). Their fundamental critique was particularly concerned with the problematisation of forced treatment. Furthermore, questioning the validity of psychiatric diagnoses, Szasz (2003, 1974) argues that the problems of everyday life, however troublesome and painful they may be, should not be treated with strong psychotropic drugs if evidence of any physical etiopathology is missing.

However, lack of empirical evidence in psychiatry has a long history (Eisenberg and Guttmacher, 2010), and 'like in other areas in psychiatry, questionable genetic theories and brain dysfunction theories of ADHD continue to cross-validate each other' (Joseph, 2009, p. 59).

More recently a body of literature began to emerge under the umbrella term 'critical psychiatry'. While critical psychiatry shares some of the critique of anti-psychiatry, it aims to overcome the dichotomy of biomedical reductionism (see, inter alia, Barkley, 2002) and the denial of mental illness, as visible throughout the work of Szasz (2003, 1974). The essential position of critical psychiatry is the rejection of biological reductionism i.e. 'functional mental illness should not be reduced to brain disease' (Double, 2019, p. 61). Rather, a biopsychosocial model is proposed that takes account of the lived experiences of individuals (cf. Engel, 1977). As opposed to biomedical reductionism, such a model takes account of cultural, social and psychological considerations, while not denying biological factors. As opposed to anti-psychiatry, critical psychiatry acknowledges the significance of culture and suggests that psychiatric practice needs to develop culturally sensitive and locally relevant approaches (see, inter alia, Fernando, 2014). In line with this orientation, David Walker (2006) argues that the concept of ADHD is far from being culturally neutral. He uses the example of native American children to claim that modern concepts of ADHD seem to be rooted in eugenics and mental hygiene (i.e. the idea that the correct socialisation of children would lead to perfect societies, see Richardson, 1989, p. 2). Rather than diagnosing and medicating these children, their struggles should be understood as the result of the internalisation of oppression.

In summary, critical psychiatry offers a framework to challenge biological reductionism and 'mechanistic psychological approaches' (Double, 2019, p. 62). It advocates for a rights-based approach that consequently puts the person in focus. There remain, however, areas of disagreement, including whether psychiatry should be regarded as a medical discipline, whether all

forced treatment should be abolished, and whether mental disorder should be regarded as illness and disease (ibid.).

### **Diagnostic Practice**

Although practice varies significantly, it is reasonable to argue that diagnostic labels frequently serve to legitimise the use of stimulants post hoc (Armstrong, 2006; Conrad, 1975). While prescriptions are issued by physicians, many other professionals are involved in the processes of identifying, assessing, diagnosing and treating children who display 'deviant behaviour', including social workers, child care workers and nurses (Cohen, 2006b). Assessment processes have been criticised for neglecting social and family dimensions (2006b, p. 144). As Timimi argues, '[t]he more contexts we know the more intelligible the behaviour becomes and the easier it is for us to relate to and understand this behaviour' (2009a, p. 143). In a similar vein, Nikolas Rose suggests an 'integrative biopsychosocialcultural formulation' to account for the 'fullness of human nature and the complexity of the social environment' (Rose, 2019, p. 90ff). Yet, current diagnostic practice tends to dismiss these contextual factors, particularly since the advent of the DSM-5. Rather than implementing rigorous assessment and intervention alternatives, assessment is often reduced to whether children 'could benefit from medication' (Cohen, 2006b, p. 152).

### **Alternatives to Pharmaceuticals**

It has been argued that behaviour in children should be understood, not simply be 'managed' (Jureidini, 2009; Karnik, 2001), and that practice needs to go beyond the mainstream, overcoming the dominant idea of framing children's conduct solely in diagnostic terms (Radcliffe and Newnes, 2005). Challenging the hegemonic medical approach, reports highlight the usefulness of non-pharmacological interventions (Abrines et al., 2012; Toplak et al., 2008). Strong evidence has been reported for the effectiveness of family-centred therapeutic interventions, including Incredible Years Programme, Parent-Child Interaction Therapy, Triple P, and Behavioural Therapy (Cormier, 2008; LaForett et al., 2008; Wagner and McNeil, 2008).

The review of Antshel and Barkley (2008) suggests that behaviourally-oriented psychotherapeutic interventions are comparable to pharmaceuticals in their effectiveness. This stance receives support from both the three year and eight year follow up of the MTA study. While non-pharmaceutical interventions have been reported as effective as pharmaceuticals in the therapy of ADHD, they come with far less adverse effects (Jensen et al., 2007; Molina et al., 2009). Further promising approaches include school social work (Cohen, 2006b), neurofeedback (Steiner et al., 2014), pedagogics (Gebauer, 2008), systemic therapy (Bonney, 2008a), nutrition (Puri, 2009) and psychoanalysis (Hopf, 2015). However, there is a gap in the literature regarding the effectiveness of these approaches, and the heterogeneity of existing studies complicates their comparability (Bachmann et al., 2008). While there is a growing body of literature supporting the efficacy of non-pharmaceutical interventions in the treatment of ADHD, such alternatives to medical treatment are often 'virtually nonexistent' or 'simply unavailable' (Cohen, 2006b, p. 145). Arguably, social work may play a vital role in filling this gap (Thomas and Corcoran, 2003). I discuss this, however, in the discussion chapter (cf. **Implications for Social Work**, p.268).

## **Environment**

John Davies (2006), drawing on childhood and disability studies, argues that there is a need to develop a progressive approach to ADHD in order to account for the complexity of factors shaping the discourse on childhood behaviour, including the tensions between adult control and child self-realisation. He further argues that

[t]he social model of disability can be employed to underpin the suggestion that ADHD is purely a social construct (2006, p. 48)

This perspective highlights that processes of normalisation and socialisation in children's lives can only be understood when acknowledging the interplay between individual agency and wider issues. The next sections aim to introduce some critical accounts of the social construction of ADHD.

## School and Governance

Ever since the introduction of mass education (see earlier in this chapter), children have been subjected to a variety of techniques aimed at rendering their behaviour docile. It is against this background that schools are subjected to constant monitoring by the government (Hinshaw and Scheffler, 2014), and expected to prepare an ever-growing population of higher educated people (Timimi, 2009a, p. 149). As Tait suggests,

[a]t school, children learn to make appropriate, sanctioned decisions on the assumption that they will be held accountable for transgressions. Governance is thus ultimately founded upon self-governance, and in turn, self-governance itself is founded upon a number of crucial assumptions, the most significant of which is the belief that we all have the capacity to make free choices and that we can be held accountable for these choices (2006, p. 83ff)

In contemporary minority world conceptualisations of childhood (see earlier in this chapter), though, expectations of conformity and self-control in schools are in a paradoxical conflict with the idea of early childhood as a period that is relatively free from such constraints (Cooper, 2001). As a site where the conduct of children becomes monitored and assessed on a daily basis, the school contributes to an increasing tendency to problematise certain behaviours (Cohen, 2006b). There is a large body of educational literature on children labelled with 'ADHD' that holds the premise that these children are 'fundamentally different' and that teachers will need to 'manage them' in the classroom (Lloyd et al., 2006b, p. 221). Against this backdrop the school serves as a means to help children acquire a decent attitude towards their 'disorder' (ibid.). In other words, these children are, through discursive practices, taught 'how to be handicapped in a normal setting' (Hjörne, 2006, p. 195).

Ironically, the origins of many behavioural problems appear to lie in the very character of the school system (Thomas, 2005), which in turn promotes the diagnosis and treatment of ADHD through drug therapy (Baldwin, 2000). The cultural pressure imposed on children, and the endeavour to standardise and speed up their development, may potentially lead to the pathologisation of immaturity (Armstrong, 2006). Generally, educational demands increasingly

seem to lead to mental health issues in children (Ecks and Kupfer, 2015). Moreover, Cohen (2006b) suggests they are the main means of justifying decisions to prescribe psychotropic drugs. Critical accounts have challenged the practice of school exclusion in relation to ADHD (Lloyd and Norris, 1999), portraying children as victims of the system, with particular reference to 'the effects of educational performance ratings on the school's decision making' (Horton-Salway, 2018, p. 89). Such accounts tend to represent ADHD as a learning disability (ibid.).

## **Culture**

Sociological and anthropological insights into childhood and child rearing suggest that there is a huge variety of practices and beliefs around the world, changing across different cultural contexts and over time (Timimi and Maitra, 2009), and that both 'hyperactivity' and 'disruptiveness' are highly culturally constructed identities (Mann et al., 1992; Sonuga-Barke et al., 1993). In addition, the way we perceive children and childhood has undergone significant changes in the past two centuries (Timimi, 2005). Considering these changes as possible environmental causes of what we currently call 'ADHD' thus also includes elaborating upon social, political and cultural factors that shape the discourses around childhood and child rearing. Scholars have argued that changing diet and nutrition (Puri, 2009), family structure and lifestyle (Kincheloe, 1998; Stiefel, 1997), changes in the education system (Timimi, 2005), childhood abuse and trauma (Karnik, 2001; Whitfield, 2006) all may be regarded as environmental biopsychosocial causes of behaviours labelled 'ADHD'. Yet, despite the relevance of this large body of literature to child and adolescent mental health (Timimi and Maitra, 2009), power relations in the social construction of deviance, such as the influence of the pharmaceutical industry, the medical profession, the (de-)regulatory state and advocacy groups (see earlier in this chapter), have prevented its inclusion in the dominant discourse on ADHD (Lloyd, 2006).

## **Globalisation of ADHD**

The conceptualisation of 'normal' and 'deviant' childhoods, and the proliferation of them around the world, has arguably led to a globalisation of minority world visions of children's mental health and its treatment with psychotropic drugs. This suggests that more helpful indigenous concepts may be undermined or completely ignored (Timimi, 2005). However, there is a paucity of research regarding the expansion of ADHD into the international sphere (Conrad and Bergey, 2014).

There are great disparities in the use of ADHD diagnoses and particularly the use of stimulants in children (Hinshaw et al., 2011), while systematic explanations for these differences are still lacking (Skounti et al., 2006). Epidemiological evidence suggests that the concept of ADHD is well established in the minority world (Cohen, 2006a). More recent work indicates that the concept is expanding around the globe. These include accounts of the emergence of ADHD in Argentina (Faraone and Bianchi, 2018), Brazil (Ortega et al., 2018), Chile (Rojas Navarro et al., 2018) and Ghana (Bröer et al., 2018). Meta-analyses regarding the prevalence of ADHD around the globe suggest that the majority of studies have been conducted in North America and, more recently, Europe, with less data available regarding countries in Asia, the Middle East, Oceania and South America (Polanczyk et al., 2007, 2014). Particularly scarce, however, are studies in African countries. Bröer et al. (2018) suggest that their Ghanaian study is the first to cover a sub-Saharan country, except for South African research. Their findings indicate that ADHD is not yet an established concept in Ghana. Although psychiatric diagnoses in general tend to increase, concerns in relation to children's behaviour are 'often couched within a spiritualistic explanatory model' (ibid., p.355). It is against this background that they suggest

that corporal punishment, traditional healing, and prayer seem to remain the first treatments for children who are brought to the attention of clinicians who diagnose and treat ADHD (ibid., p.355)

They further suggest that ADHD may be 'a niche in the making', and that what seems to be at stake is primarily 'disrespect for parents, teachers, and the elderly', rather than academic performance, when diagnosis and medication are sought (ibid., p.355). These concerns regarding the disrespect for adults indicate cultural differences in the conceptualisation of children. As opposed to minority world constructions of childhood, African (and, more generally, majority world) countries tend to be less interested in children as individuals with rights of their own, and more concerned with them as part of families and communities and who are endowed with both responsibilities and rights. This is particularly visible in Article 31 of the African Charter on the Rights of the Child, which states that 'every child shall have responsibilities towards his [sic] family and society' (OAU, 1990).

Epidemiological data on the nature, prevalence and treatment of psychiatric disorders in children and adolescents in Switzerland are largely absent, both on a national and cantonal level (Rüesch and Maeder, 2010). Studying 1964 pupils in the canton of Zurich, Steinhausen et al. (1998) found a general prevalence rate of psychiatric diagnoses of 22.5% in children aged 6-17 years. The youngest category of children (6-9 years) was significantly overrepresented (33.1%), possibly reflecting the tendency to pathologise immaturity in younger children (Armstrong, 2006). Gummy et al. (2010) suggest that although the prevalence rate of ADHD in Switzerland is lower than in the US, some aspects are similar, including the general increase in prescription rates in the last decade. These rates almost doubled between 2006 and 2012, but the reasons for this phenomenon remain elusive (Rüesch et al., 2014). It has been argued that pressure to perform to a high standard may increasingly lead to 'deviant behaviour' in children, which in turn becomes problematised and managed in medical terms. The demands of contemporary Swiss classrooms, therefore, seem to significantly drive psychiatric diagnoses in children (Steinhausen and Winkler Metzke, 2002). A more recent study on ADHD in Swiss children concluded that there is a need to develop holistic approaches in order to help children with behavioural problems (Hotz, 2016).



## **Class, Race and Gender**

Contemporary constructions of childhood, such as disciplinary processes in schools, are gendered, classed and racialized (Lloyd and Wright, 2005; van Ausdale and Feagin, 2001). Acknowledging how gender, class and 'race' increasingly receive attention in the critical humanities, Hanan (2019, p. 113) suggests that similar reflections should be adopted to elaborate upon 'the implicit and explicit ways these disciplines perform ableism'. Talking about the relationship between class and ADHD prevalence, Hart & Benassaya suggest that

[t]he social distribution of the disorder follows the contours of a class mortality gradient. In other words, it fits the classic profile of health and inequality: low prevalence at the top, and high prevalence at the bottom of the social hierarchy (2009, p. 229ff)

In their examination of the media representation of ADHD, Schmitz et al. found that it is predominantly young white boys who are depicted as the 'most likely persons to have ADHD' in the US media (2003, p. 400). In a similar vein, Schneider & Eisenberg, in their research on the prevalence of ADHD in the US, concluded that 'black children, and Hispanic children were less likely to have the diagnosis' (2006, p. 601). However, Hart & Benassaya, writing about the US as well, suggest that 'irrespective of race, approx. 12 % of boys were reported as suffering from ADHD' (2009, p. 235). More recently, Coker et al. (2016) concluded in their study that, in all age groups, white children were overrepresented in both diagnosis and treatment as opposed to 'African-American' and 'Latino' children. Such controversial findings support the argument of Comstock that 'there is a great deal of disagreement over the relation of race and class to ADHD' (2011, p. 49). Despite these converse views, class is frequently being employed in moralising discourses as an explanation for children's educational failure (Davis, 2006). Hotz, who led a recent interdisciplinary project on ADHD in Switzerland (2017, 2016), argues that recruitment practices may also lead to a certain bias in the research findings. Often, those parents who are committed to such projects are of a white, middle-class background (Hotz, 2019).

There is less disagreement, though, regarding the findings relating to gender. ADHD is significantly more diagnosed in boys than in girls. Arguably, an important reason for this is that boys tend to display 'externalised behaviour' more frequently than girls (Liu, 2004). Generally, there runs a certain 'fear of harm' narrative throughout the discourse that is biased towards depicting 'dangerous masculinity' and that constructs ADHD as 'a dysfunctional condition of boyhood' (Horton-Salway, 2018, p. 87ff). This gendered stereotype (cf. Schmitz et al., 2003) that is transported throughout the discourse on ADHD, and that labels the behaviour of boys as an illness, has been critiqued as 'a sort of sexism against boys' (Clarke, 2011, p. 626). Linking this dangerous masculinity to adult crime, Horton-Salway argues, serves as a means 'to justify medicating young children who have ADHD, particularly boys', while 'the less common depictions of girls with ADHD' that are constructed through discursive practices 'are not typically demonised or focused on the issue of medication' (2018, p. 89). Furthermore, special needs support is four times more likely to affect boys, which resonates with much higher rates of diagnosed learning disabilities in boys than in girls. Statistics have shown that the younger the boys in their class, the more likely they are to be put on stimulant medication (LeFever et al., 1999).

While the majority of children labelled ADHD are boys, it is overwhelmingly adult females who initiate the process of diagnosing children. Obviously, this reflects in part the greater involvement of women in the lives of young children. However, research has shown that parents frequently disagree on the 'pathological' nature of their sons (Timimi, 2009a). Research also indicates that it is predominantly the mother who is managing the medication for a child labelled with 'ADHD', while fathers tend to be more reluctant or even to sabotage the pharmaceutical 'management' of their children's behaviour (Kirsch and Wischnewski, 2010). Moreover, research suggests that in families in which a child has been diagnosed with 'ADHD', mothers tend to show less warmth and support than fathers (Tancred and Greeff, 2015).

This short paragraph cannot give justice to the ways in which class, 'race' and gender 'simultaneously obscure and reinforce unequal relations of power' (Smith, 2012, p. 35) in discourses around childhood in general, and ADHD more specifically. Given the disagreements discussed above, each of these categories would justify a perspective through which further research on ADHD could be conducted. While, in the context of this research, none of these categories constitute a central prism through which to explore the discourse on childhood ADHD in Switzerland, they will nevertheless be picked up and developed further throughout this thesis.

### **ADHD and Parenting**

Mayall (1996) argues that the dominant discourse around child rearing constructs parents as the central bearers of responsibility to socialise their children towards specific behaviours and social norms. As Davis (2006, p. 49) argues, '[a]t its most extreme, this moral discourse is believed to pressure parents into using drugs to control their children's behaviour'. However, the same discourse also offers a relief in the form of a 'label of forgiveness' (cf. earlier in this chapter). In a culture where 'psychosocial explanations' may well 'translate as parental blame in the public imagination' (Horton-Salway, 2018, p. 71), and mostly accuse the mother (Singh, 2004), medical diagnoses and pharmaceutical treatment may serve to ease the guilt of parents, particularly mothers (Timimi, 2009a). In the medical literature there is a strong focus on moving responsibility away from the human agent. Messages destined for parents have strong guilt-dissolving components, claiming for instance that 'ADHD is nobody's fault' and that '[n]othing you or your child has done has caused it' (Armstrong, 2006, p. 12). While blaming mothers for their children's behaviour is clearly unhelpful, excluding all family-related factors from explanations may be equally unhelpful (Lloyd, 2006). The scientific evidence indicates that adverse parenting, difficult family circumstances and suppressive school environments contribute to emotional and behavioural problems in children (Öngel, 2006). In addition, research suggests that 'ADHD behaviour' may be a sign of insecure attachment (Clarke et al., 2002; Erdman, 1998; Greenberg et al., 1993) and a reaction to

traumatic experiences (Herman, 2001; van der Kolk et al., 2000). Gray Brunton et al. argue that there is a lack, though, of research into how parents perceive their child's behaviour, and suggest that this is problematic, since 'diagnoses of children's ADHD rely heavily on parental reports' (2014, p. 243).

After these elaborations upon medical practice and environmental factors shaping the discourse around ADHD, I will now introduce a perspective that draws on ethics and human rights.

## **Children's Rights**

The United Nations Conventions on the Rights of the Child (UN General Assembly, 1989, hereafter CRC) significantly shaped the view of children in that it gave them rights on their own (Kerber-Ganse, 2009; Rudin, 2011a). It is against this backdrop that Ayling (2006) argues that young people should have independent access to health services if they feel unsafe in their environment. In a similar vein, Jacobson (2006) highlights the agency and capability of children with respect to important decisions affecting their lives. The CRC thus emphasises the 'individualised' child, which has, however, been critiqued for reflecting minority world values (Collins, 2017, p. 29). As Comstock argues, the individualisation of children arguably enabled drug treatment to happen in that

[e]ach behavior is given its value no longer in relation to moral systems but relative to an economy of self in which each behavior functions. In other words, it is only in relation to the self that a behavior can be valued... The essential 'paradox' that stimulant medications in fact resolve is the paradox of the individual that does not organize the self in keeping with their best interests and, indeed, their 'survival' (Comstock, 2011, p. 63)

This section elaborates upon the ethics of treating children with performance enhancing and mind-altering drugs and then goes on to discuss the (absent) voice of children in the discourse on ADHD.

## **The ethics of prescribing performance enhancing drugs to children**

ADHD can be viewed as a case study of the potential social and ethical consequences of psychiatric diagnosis and treatments (Singh, 2011). Diller (2009) argues that human enhancement became popularised over the last three decades. Prescribing performance enhancing and mind-altering drugs to children raises questions about unfair advantage over classmates (Armstrong, 2006) and ethics (NEK-CNE, 2011). Medics consequently seek to legitimise their use by claiming that ADHD is a 'real disorder', and by comparing it to more commonly accepted medical practices such as the use of insulin in the treatment of diabetes, or the wearing of eyeglasses (Ray and Hinnant, 2009). Rather than ignoring cultural shifts in the acceptance of performance enhancers, Cohen (2006a) argues, the drugging of children to improve their school performance should be discussed openly.

Forcing a child to take psychotropic drugs, though, may undermine children's fundamental rights and may designate a form of bodily harm (DGSP, 2013). Furthermore, the benefit of treating children with psychotropic drugs is often assessed through parental satisfaction with the medication, ignoring the voices of children themselves (Leo and Lacasse, 2015). Let us consider the (missing) voice of children in some more depth.

## **The Voice of Children**

The CRC considers participation of children in all matters concerning them as one of its core principles (Kerber-Ganse, 2009). In the wake of shifting understandings of the child and childhood, the Committee on the Rights of the Child has highlighted in its *General Comments Nr 12* that participation

has evolved and is now widely used to describe ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect (2009a, p. 5)

However, medical models of childhood development have been criticised for failing to involve children in the process of diagnosis (Baughman and Hovey, 2006) and for reducing them to passive objects (Davis, 2006, p. 55). It is against this backdrop that the voice of children is rather marginalised in

debates around the rights of children in general (Liebel, 2007), and about medicalisation in the context of 'ADHD' in particular (Amft et al., 2004). While some attempts have been made to include children's accounts of ADHD (Haubl and Liebsch, 2010a; Singh, 2013), their involvement in the discourse still needs to be strengthened.

A study that addressed this gap, led by Haubl and Liebsch (2010a), investigated the views of 60 boys aged 9-14 years who were medicated with stimulants. These children tended to be much more critical about the usefulness of medication, and some of them argued their agency was undermined through the effects of the drugs. For example, one boy described himself as 'robot' while under the influence of stimulants. In a similar vein, Schmidt (2019) argues that children learn like 'Zombies' when subjected to such drugs. This has been interpreted as a 'loss of sensitivity, a mere functioning' and, more broadly, as a perceived 'self-alienation' (Jentsch, 2010, p. 104).

Haubl and Liebsch (2010b, p. 204ff) have identified a typology of positive and negative representants of the medication in boys. Accordingly, boys describing the effects as being positive perceive the drug either as a means of (i) social pacification {soziale Befriedung}, of (ii) voluntary self-control or as (iii) (school) performance improvement. Boys representing the first type argue that relationships with significant people around them, foremost mothers, have been improved. This effect may take place even if the boys themselves do not recognise any difference in their behaviour. Boys constituting the second type perceive drugs as expanding their opportunities for action, regardless of whether the objectives are self-directed or externally determined. Finally, boys representing the third type agree to take the drug because it makes them more efficient, while their primary interest lies in improving their school performance. Those children described as 'hyperactive' primarily fall into the first type, while boys who are described as not outgoing enough are primarily found among the third type. In the second type, boys diagnosed with 'ADHD' and 'ADD' are found equally.

Negative representations were typified by the researchers in parallel to the positive representations. These included the drug as (i) a means of violent submission, as (ii) painful dependence and (iii) as self-alienation. Boys representing the first type perceive medication as a means of violently subjecting them to prevailing social norms. Boys constituting the second type experience difficulties with self-control. Since acquiring this competence is a rather strenuous process, the child may be welcoming the help of medication in the short term. However, because the medication makes the child's ability dependent on swallowing the drug, the child may perceive this dependence as rather negative in the long term. Finally, boys representing the third type may perceive medication negatively if drugs are used to increase their performance against their will. If the child does not recognise himself in the abilities that are sought to be improved by the discourse shaping their life, then they may perceive this process as a painful self-alienation. Haubl and Liebsch (2010b) conclude that children do not clearly fall into one positive or negative type. Rather, their perception of the usefulness of medication is an ongoing ambivalence, largely shaped by their environment and the expectations of significant people around them.

Generally, children receiving pharmaceutical treatment tend to be more critical about the usefulness of their medication than adults around them (Haubl and Liebsch, 2010a). This claim finds support in research recently conducted in Switzerland (Esslinger and Schöbi, 2017). On the question 'I am glad to take medication because of the ADHD', only 25% of the children interviewed responded with 'yes', while 32.5% responded with 'no', 27.5% with 'sometimes', and 15% chose to leave the question unanswered. Regarding 'Does your ADHD medication have an influence on your distress?', only 30% of the children answered 'my distress decreases', while 15% said 'my distress increases', 45% said it has 'no influence', and 20% chose to not answer the question. While these results need to be interpreted with caution because of the small sample (n=40), they nevertheless indicate that there is most probably a significant difference between how adults and children tend to make sense of medication and rate its usefulness.

Unfortunately, the design of this study did not allow for elaborating more qualitative aspects of medicalising children. Hence these numbers are left to interpretation regarding why children perceive medication in the way they reported it.

## **Summary**

This section has introduced a counter-discourse that challenges the hegemonic conceptualisation of 'ADHD'. This has included the problematisation of medical research, psychiatric practices and the overreliance on pharmaceutical drugs in the treatment of children. I have argued that while there is a growing body of evidence demonstrating the favourable effects of non-pharmaceutical treatments, they are largely unavailable. The discussion then went on to explore environmental factors affecting children's behaviour, including culture, class, 'race' and gender. I argued that while there is a clear tendency to drug boys, there is less agreement regarding how other social dimensions affect diagnostic and treatment practices. The final part has introduced a children's rights perspective. I have argued that there are significant ethical questions arising around pharmaceutical interventions in children, and that the voice of children themselves is largely absent in the discourse.

The next section draws together the arguments brought forward throughout this literature review and indicates the research approach taken.

## **Conclusion**

This review of relevant literature has engaged with the discourse on ADHD through four distinct but related perspectives. Firstly, some wider discourses that enabled the emergence of ADHD, including the introduction of compulsory schooling and the institutionalisation of public health have been discussed. Moreover, the interdisciplinary field of the new social studies of childhood, which aims to challenge many taken-for-granted assumptions about children has been introduced. I have argued that the discourse around



ADHD, and indeed the controversies around its causes and best treatment, is entangled with these wider discourses.

Secondly, a genealogical perspective has suggested that the concept of ADHD has evolved out of a discourse that was from the beginning tightly linked to ideas of docility and normality in children. In the wake of a shift from psychoanalysis to pharmacology, the way we tend to understand deviant behaviour in children has increasingly been framed by ideas of biological reductionism.

Thirdly, a number of key drivers of the popularisation of ADHD have been identified, including consumerism, ideology of the regulatory state and the media. I have argued that the role of the pharmaceutical industry in Switzerland may be different than in the US (where much research on these drivers is based) since, unlike in the US, direct-to-consumer marketing is prohibited in the Swiss market.

Finally, the construction of knowledge on ADHD has been problematised through drawing on critiques from a range of disciplines. The discussion has illustrated that medical practice seems to return to a biological determinism, while ignoring environmental factors, in the emergence of behavioural patterns that have been labelled as 'ADHD'. Additionally, the discussion has introduced a children's rights perspective and highlighted some ethical implications of subjecting children to mind-altering drugs.

Acknowledging the paucity of research into how the concept of ADHD is increasingly being adopted around the world (Conrad and Bergey, 2014), and suggesting that the conceptualisation of 'disorders' may best be understood as a modern art of government (Tait, 2006), this thesis adopts a governmentality perspective to analyse the discourse on childhood ADHD in Switzerland. While, more recently, there has been an increase in discursive studies on ADHD, many of these have been limited to the US or the UK, leaving much of the further minority world (and indeed the majority world) unexplored. Furthermore, the adoption of a governmentality perspective has

largely been underexploited in discursive research into ADHD, although there are notable exceptions (see, inter alia, Bailey, 2013, 2010; Hanan, 2019; Tait, 2006, 2001).

This study engages with the discourse on a number of discourse planes, i.e. the media, politics and advocacy groups (discourse planes are the social location from which speaking takes place, cf. **The Structure of Discourses**, p.98). These discourse planes were chosen in relation to the key drivers of the popularisation of ADHD as discussed earlier in this chapter.

In terms of context, this study acknowledges that there is very limited research available on ADHD in Switzerland as compared to the US and the UK. Moreover, to my knowledge, no research has yet applied a governmentality perspective to examine the discourse on childhood ADHD in Switzerland. Due to its four language regions (Swiss German, French, Italian, Romansh), Switzerland is particularly interesting to study, as it allows examination of whether there are cultural differences in the discourse around ADHD across these regions.

As has been argued in this review of relevant literature, in the wake of the shift from psychoanalysis to pharmaceuticals, the hegemonic discourse on ADHD in the minority world has adopted a biological reductionism that informs both understandings of causes and treatment. However, acknowledging that ADHD remains a controversial entity, this study aims to identify and analyse both hegemonic and 'counter discourses' (Jäger and Maier, 2010) to draw a more comprehensive understanding of this topic and to help identify knowledges and approaches that more closely reflect social work norms and values.

The next chapter aims to introduce the reader to the research questions and the methodological approach that I have taken to address these.



### **3 Methodology**

In this chapter I will outline the methodological approach that I have taken to answer my research questions. This research is guided by an overarching question as well as three more specific questions. The overarching question is: How has the concept of childhood ADHD been established and maintained in the discourse in Switzerland as per to date? The more specific research questions are:

- (i) How are children labelled with ADHD rendered knowable and governable?
- (ii) How are children labelled with ADHD conceptualised and represented?
- (iii) How are children labelled with ADHD governed towards specific ends?

After some considerations regarding my researcher's perspective (i.e. my personal values, interests and assumptions), I will contextualise and explain the discursive approach that I have taken and describe the methods that I have used for data collection and data analysis.

#### **Researcher's Perspective**

As a qualitative researcher I am shaping both the collection and analysis of data (Willig, 2008; Willig and Stainton-Rogers, 2013). This section therefore reflects upon my personal lens through which I have conducted this research. Growing up in a middle-class family in German speaking Switzerland, I owe much of my socialisation to this cultural context. But my journey of becoming a social worker was not straightforward. After secondary education I decided

to study electrical engineering at a college in Switzerland, to which I still owe much of my structured approach to dealing with complex phenomena and problems. Yet, in the context of civilian service (a substitute to compulsory military service) in 2005 in a children's home in Switzerland, I discovered my interest in 'social problems'. This was also the first time that I came across children both being labelled with and drugged for 'ADHD'. Considering how their biographies were often significantly shaped by a range of adversities, I found this approach both reductionist and particularly problematic when it took place against their will.

Following these experiences I decided to study social work, again in Switzerland, but with a semester abroad in Ghana, West Africa. In this cultural context, and during that time (August 2008 – February 2009), the idea of 'ADHD' seemed to be almost completely unknown. Later, in 2013, when I started my work as a representative of the International Federation of Social Workers to the United Nations, I was invited to write two brief contributions towards a shadow report (cf. Child Rights Network Switzerland, 2014) on the implementation of children's rights in Switzerland, addressed to the United Nations Committee on the Rights of the Child in Geneva. I took a rather pragmatic approach and derived two 'pressing issues' regarding children from the media plane: the reproduction of social inequality within the Swiss education system, and the rise of psychotropic prescriptions in children in the context of 'ADHD'. These contributions also provided the basis for an interview that I gave in 2014 to a Swiss newspaper (Nowotny, 2014) which rendered my critical stance publicly visible. In the wake of this interview I was invited by the Swiss Federal Office of Public Health (hereafter FOPH) to review a draft report (cf. Eckhardt, 2014) regarding the use of psychotropic drugs in children, which I accepted. I saw and still see my role in such contexts as a plea for more environmentally aware approaches, which I consider a core value of social work. Additionally, as a social worker I value the concepts of human rights, human dignity and social justice and consider both societal and individual perspectives important in addressing human needs (cf. Rudin, 2011a). This contrasts, to some extent, with modern

psychiatry, which emphasises individual weakness and biological reductionism. Arguably, my social work stance thus has a strong influence on both data collection and analysis. There is a certain emphasis on the identification of 'counter-discourses' (Jäger and Maier, 2010) in the data that challenge medical reductionism.

My critical stance brought me into contact with like-minded scholars, both within and beyond the profession of social work. Through becoming a member of the advisory board of the Germany-based Conference on ADHD (2020) in 2015, I was able (and certainly continue) to learn more about the controversies around 'ADHD'. My knowledge and experience of this phenomenon are accordingly more than that which has been gained through my thesis.

A predilection for reductionism and the recourse to medical explanations for behaviour displayed in children, though, are not limited to medics. Even within social work, medical explanations and diagnostic tools may be adopted in the wake of professionalisation discourses (I will come back to this in the discussion chapter, cf. **Perspectives for Social Work**, p.281). For instance, in the US clinical social workers are diagnosing children with 'ADHD' using the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). While social workers in Switzerland do not diagnose 'psychiatric conditions', my experience is that there is, nevertheless, a great deal of dissonance regarding the perceived role of social work in the context of children displaying 'deviant behaviour'. Elaborating on the process of professional socialisation, Reinharz (2017) suggests that encountering such conflicts and dissonance is common. Reflecting on what I personally think social work is about, and what was taught at the university during my social work training, is consequently part of my personal socialisation process as a social worker. This includes an iterative process of critically examining, synthesising, accepting or rejecting concepts.

This thesis thus further adds to my own professional socialisation process, but also aims to contribute to shaping the profession of social work towards

(more) anti-discriminatory and anti-oppressive practices. In line with Mührel (2018, p. 82), I perceive phenomena such as 'ADHD' and 'depression' at least in part as the 'psychiatrisation of social problems' in the light of environments that may be hostile to children (and adults alike). It is against this position that I am interested in how the concept of 'ADHD' has been established and maintained in Switzerland. Although I prefer more interactive and participative research approaches, such as interviews and action research (cf. Shamrova and Cummings, 2017), as they fit well with the social work values described above, I had to change my approach in the course of the first year of my PhD project. I soon realised that such approaches would not be suitable to answer my research questions.

In particular, the processes through which (hegemonic) knowledge about 'ADHD' is both produced and circulated does not necessarily form part of social work training and practice. In the light of the drivers of 'ADHD' that I have identified in the literature review (cf. **Central Drivers of the ADHD Phenomenon**, p.40), I accordingly decided to change my approach to include discourse planes that are more suitable to address my research questions, namely the political, media and parents' advocacy planes. I am aware that this is a rather macro-perspective approach. However, this appears to be in line with the way I tend to approach complex phenomena (which probably reflects my engineering training). Considered as a necessary first step, this project therefore sets the basis for further research, beyond the scope of this thesis, that focuses more on meso- and micro level discourse.

While I have discussed some of my personal values, interests and assumptions in this section, I reflect upon how these may have affected my research in the discussion chapter (cf. **Reflections**, p.296). Let us now consider the discursive approach that I have taken to conduct this research project.

## Definition of Childhood

Throughout this thesis I use the term 'childhood', a term that may bear different meanings, depending on context. It may therefore be useful to provide the reader with some insights regarding my own understanding and working definition of 'childhood'. Generally, this term refers to the state of being a child, which is usually defined within a legal framework and demarcated by a specific period in the life of a human being (van Bueren, 1998). For instance, the United Nations Convention on the Rights of the Child defines a child as

every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier (UN General Assembly, 1989)

Conceptualisations of childhood tend to divide the period of the state of being a child into different phases. For example, Bogin (1999, p. 30) suggests the following: infant phase (0-3 years), childhood phase (3-7 years), juvenile phase (7-11 years) and adolescence phase (11-18 years). In a similar vein, my own working definition considers 0-3 years of age as early childhood, 4-7 years of age as middle childhood, 8-11 years of age as late childhood, and 12-18 years of age as adolescence. While such definitions are necessarily artificial and arbitrary (van Bueren, 1998, p. 32), they are nevertheless useful in accounting for differences in children in relation to their age and development. Considering the data collected in this study, the focus of the discourse on ADHD lies on middle and late childhood, with only few references to early childhood and adolescence (I discuss this, and how it resonates with previous research, in the final chapter, see **Conceptualising and Representing Children**, p.261).

## General Discursive Approach

Discourse analysis generally adopts a problem-oriented, interdisciplinary approach in order to investigate complex social phenomena. In this section I aim to elaborate on the constitutive ideas and concepts of the specific



approach I have taken to analyse the discourse on childhood ADHD in Switzerland and offer some contemplations on strengths and limitations.

## **Introduction**

Discourse, in its broadest sense, refers to the use of language in both written texts and conversations and its role in social life (Cook, 2008). It may describe 'anything from a historical moment, a lieu de mémoire, policy, a political strategy... to language per se' (Wodak and Meyer, 2009, p. 2). Researching discourse has been a growing interest in academia since the mid-1990s (Potter, 2008), and there is a great variety of theoretical frameworks adopted, terminology used and approaches taken. It is consequently necessary to briefly outline the path I have chosen for my own study. Discourse analysis can be regarded as an umbrella term that covers a range of approaches, and it is common to distinguish the subfields of Foucauldian Discourse Analysis, Critical Discourse Analysis and Discursive Psychology (Potter, 2008). These approaches vary from what may be called 'bottom-up' approaches that undertake inductive, detailed case studies and focus on micro-processes of discourses, as demonstrated by Martin Reisigl and Ruth Wodak (2010), to what may be termed 'top-down' methods that adopt a rather deductive, general perspective and focus on broader political and cultural contexts of discourses, as exemplified by the work of Norman Fairclough (2010, 2009). As Wodak and Meyer argue, however, 'all approaches moreover proceed abductively, i.e. oscillate between theory and data analysis in retroductive ways' (2009, p. 19).

In my own research I have chosen an approach that falls within the subfield of Foucauldian Discourse Analysis and strongly builds on the philosophical and sociological work of Michel Foucault. Foucault aimed to shed light on how discourse produces objects, such as 'ADHD', and identities, such as those of doctors, teachers, parents and (school)children. A Foucauldian approach to discourse aims to contextualise discourses in their historical emergence. Such a genealogical approach (cf. Foucault, 1989) allows consideration of the constitutive parts of discursive practices in their

contemporary form and linking them to their historical development. In Foucauldian approaches discourses are understood as institutionalised rationalities that are linked with agency and that exercise power (Bartel and Ullrich, 2008). For Foucault, discourses are productive in that they produce the objects of which they speak. Sexuality, madness or, in the case of this research, 'ADHD' are not natural occurrences but constructed realities and truths that are entangled with power. As Carabine (2001) emphasises, discourses thus establish and maintain what counts as 'truth' at a specific point in time. By doing so, discourses are not only a reflection of reality but produce subjects and form material realities (Link, 1992).

Yet, despite the enormous influence of Foucault's work on discourse analytic approaches, he did not offer a method as such (Potter, 2008). Rather, his work may be used as a 'toolbox' (see, for example, Carabine, 2001; Fairclough, 2010). The next section briefly elaborates on the main concepts and ideas that constitute the 'tools' used in this research.

## **Main Concepts and Ideas**

This research is informed by Foucauldian concepts, including genealogy, archaeology, and the nexus between power and knowledge. Furthermore, the 'critical impetus' (cf. Jäger and Maier, 2010) has inspired my analytical approach. It emphasises the usefulness of interdisciplinarity, a stance, I would argue, that should be a core commitment within both academic research and human rights-based practice in social work. I briefly introduce these constitutive parts of my discursive approach in the following sections.

### **Discourse, Power and Knowledge**

Foucault (1989, 1980) argues that discourses are entangled with knowledge and power. As an effect of power, knowledge both constitutes and is constituted through discourses. It is useful to distinguish knowledge and 'truth' claims. As Carabine puts it:

discourses are historically variable ways of specifying knowledges and truths, whereby knowledges are socially constructed and produced by effects of power and spoken of in terms of 'truths' (2001, p. 275)

Throughout his work Foucault highlights the historical and social construction of such 'truths' that we build our understanding of the world upon. He suggests that 'truth' be understood as 'a system of ordered procedures for the production, regulation, distribution and circulation of statements' (Foucault, 1977, p. 14) and highlights the entanglement of these truths with power. Foucault suggests that such a system of ordered procedures

is linked by a circular relation to systems of power which produce it and sustain it, and to effects of power which it induces and which redirect it. A 'regime' of truth (ibid., p. 44)

Deconstructing these truths and the 'regimes' that establish them enables the researcher to identify the constitutive parts of discourses that form understandings we tend to take for granted. For example, in his work *The History of Sexuality* (1980), Foucault challenges the universality of the concept of 'sexuality'. Rather than being a natural, biologically determined entity, Foucault argues, our particular understanding of sexuality has been shaped by discourses that are socially and culturally constructed and that are enmeshed with power relations. Discourses, hence, may be powerful because they designate what counts as truth and what is considered 'normal' and 'natural'. These discourses therefore establish the boundaries of what is appropriate and acceptable and define a norm against which individuals may be measured and categorised. Foucault has described these normalisation processes in detail in his work *Discipline and Punish* (1989). He understands normalisation as a form of the distribution of power and consequently challenges the idea of limiting power to its sovereign form.

According to Jäger and Maier (2010), there are two dimensions of power in relation to discourses: the power of discourse and the power over discourse. The power of discourse addresses the positivistic statements that define what is sayable and what is not sayable in a certain context at a certain point of time and how these statements form individual and collective subjects.

Discourses, understood as a form of power, 'determine the way in which a society interprets reality and organises further discursive and non-discursive practices' (ibid., p. 3). The power of discourses thus reveals itself in the way it forms individual and collective consciousness.

The power over discourse is concerned with the distribution of power regarding the influence on discourses. While some individuals and groups tend to have a high influence on a particular discourse, other individuals and groups may be marginalised. As 'flows of knowledge' (ibid., p.37), discourses have a certain life of their own and are more complex than a single subject is aware of. As a consequence, the power effects of discourse should not necessarily be interpreted as intended, manipulative acts by powerful people. While social actors do have certain intentions when using a particular discourse, the social consequences of doing so may well be diverting from these intentions. However, in the long run, certain powerful individuals and groups may well change a discourse. They are able to marginalise other groups, for example by drawing on political networks, financial resources and privileged access to the media.

As discussed above, to Foucault, the question of how discourses and their temporarily and spatially embedded knowledge are connected to power have been central in his work. The next section briefly introduces the concepts of archaeology and genealogy as a means of analysing discourses in their historical and spatial peculiarities.

### **Archaeology and Genealogy**

In his works *The Order of Things* (2001) and *The Archaeology of Knowledge* (2002) Foucault presented his idea of an archaeological method to illuminate how thought and knowledge (or, as he termed them, epistemes and discursive formations) are confined by a system of conceptual possibilities in a given spatial and temporal context. Demonstrating the application of his concept, he traces, in the *History of Madness* (2009), the different discursive practices that governed both thought and talk about the idea of 'madness' over a time span of two centuries. Foucault argues that reconceptualising the

‘mad’ to being ‘mentally ill’ and in need of medical interventions was not necessarily an improvement on earlier conceptions. Problematising the alleged scientific neutrality of psychiatric treatments of those labelled as mentally ill, he argues that psychiatry is a means to control people and align them with regimes of practice based on moral ideas, rather than healing their illnesses. To expand on this argument, this thesis particularly draws on the seminal work *Genesis and Development of a Scientific Fact* of Ludwig Fleck (1979, 1935) on the sociology of scientific knowledge. I will briefly introduce his concepts of ‘thought style’ and ‘thought collective’ under the heading Analytical Strategies later in this chapter.

Building on the concept of archaeology, Foucault developed in *Discipline and Punish* (Foucault, 1989) a method he termed genealogy. This approach enables the researcher to not only compare different discursive practices in different spatial and temporal contexts, but also to elaborate on the causative factors that drive the transition from one thought system to another. A genealogical approach to discourse analysis accordingly aims to draw a historiography of a given system of thought. It does so by using archaeology to describe the system, and problematises the discursive practices that led to its transformation. Genealogy hence facilitates not only the identification of changes in the way of thinking about things (such as ‘discipline’ and ‘madness’), but also the analysis of causative factors that led to these transitions.

By shedding light on these transitions through a ‘dialectical theory and method’ that aims to grasp things in their concatenation, discourse analysis aims to render the ‘interconnectedness of things’ visible (Fairclough, 2010, p. 39). A genealogical approach, therefore, offers a ‘lens’ (Carabine, 2001) through which to undertake a discourse analysis in order to reveal the entanglement of discourses with knowledge and power. While there is a huge variety in applying this lens in academia, the shared perspective in Foucauldian Discourse Analysis is the concern with the concepts of discourse, power and knowledge (as introduced above) in analysing data.

Emphasising particularly the usefulness of genealogy, my own approach is most closely aligned with what Carabine (2001) has termed Foucauldian Genealogical Discourse Analysis.

### **The Critical Impetus**

This thesis aims to take an explicitly 'critical' stance when it comes to analysing and discussing discourses. While critical approaches to discourse analysis cover a wide range of ontological and epistemological positions, they share a concern for critiquing and changing society rather than just aiming to understand and explain it. In order to do so, critical theory works across disciplines and integrates perspectives of various social sciences, including anthropology, human geography, history, psychology, social work and sociology (Wodak and Meyer, 2009).

Critical research emphasises the potential emancipatory aspect of knowledge. In the context of this research, I aim to offer insights into the discourse on childhood ADHD in Switzerland that are based on genealogical reflections and that draw from a wider range of social science disciplines. Through deconstructing taken for granted conceptualisations of children and childhood (cf. McNamee, 2016), I aim to add to the body of critical research in this field that seeks to enable 'human beings to emancipate themselves from forms of domination through self-reflection' (Jäger and Maier, 2010, p. 7). Critical discourse analysis consequently aims to render visible aspects of power within discourses that are often obfuscated and hidden. It endeavours to present findings and conclusions that are not only of interest within academia but are also of practical relevance.

### **Strengths and Limitations**

The next section discusses strengths but also limitations of the approach I have chosen, including working with existing and naturalistic data, the relationship between structure and agency, and the examination of taken for granted assumptions.

## **Existing Texts / Naturalistic Data**

This strand of critical discourse analysis mainly relies on existing texts, such as documents and mass media communications (Wodak and Meyer, 2009). As Webb et al. (1966) argue, reliance on existing texts has several advantages. Most importantly, it provides 'non-reactive data'. In their elaborations entitled 'approximations to knowledge', the authors argue that most social science research is based on interviews and questionnaires. Sampling and investigator bias, as well as bias coming from those interviewed, may thus significantly undermine valid interpretations of discourse. In a similar vein, Potter and Hepburn (2005) suggest that there are a number of both contingent and necessary problems arising in relation to the design, conduct, analysis and reporting of qualitative interviews. Contingent problems include the failure to consider interviews as interaction, or, where they are considered as interaction, the dependence of the analysis on the conventions used to represent interaction. Necessary problems include 'the flooding of the interview with social science agendas and categories' (ibid., p.291), i.e. how the explicit and implicit concerns and orientation of the researcher shape the conduct and analysis of interviews. Moreover, the speaker position of the interviewer and interviewee may significantly shape the interview. For instance,

are they speaking as individuals with an institutional identity or as persons with their own unique and idiosyncratic preferences? (ibid., p.293)

Potter and Hepburn suggest that where interviews are the most appropriate data gathering tools, they should be designed with critical awareness of these problems. Foremost, an interview should be studied as an interactional object, rather than as an instance of neutral and descriptive language.

Against this backdrop, the use of already existing texts, such as mass media communications, parliamentary databases or documents, may serve to avoid such bias. In addition, working with existing texts allows the researcher to generate valuable data without identifying or potentially manipulating individuals and groups (Webb, 1966).

Obviously there are alternatives to qualitative interviews, including, for instance, ethnographic observations. However, naturalistic data aim to completely avoid active researcher involvement in the production of data. While ethnographic fieldwork may be less 'interactive' than interviews (depending on the specific approach) the researcher is still the main means of data production. As Potter and Hepburn suggest, using naturalistic data not only avoids the above-mentioned problems but also comes with further advantages. For instance, using naturalistic data may bring to light novel questions and issues and 'go beyond familiar limits of memory, attention and perception' that are constitutive of interview accounts (2005, p. 301).

### **Structure, Agency and the Subject**

Foucauldian discourse theory, like other post-structuralist approaches, has been accused of overemphasising structure and ignoring the agency of individuals. Yet Foucauldian discourse theory, while contesting the existence of an autonomous subject, does not deny the subject. Rather, it is concerned with analysing and reconstructing the constitution of particular subjects in their historical and social context. One of the central positions of Foucault's writings is that the individual is not an autonomous subject but rather a product of social construction within the relations of power and knowledge that I have discussed above.

Bevir (1999) suggests distinguishing autonomy from agency when considering subjectivity in individuals. While an autonomous subject would be able to act completely outside of all social contexts and avoid the influence of regimes of practices, agents are necessarily shaped by relations of knowledge and power prevalent in the relevant social context. However, as Bevir suggests,

[a]lthough agents necessarily exist within regimes of power/knowledge, these regimes do not determine the experiences they can have, the ways they can exercise their reason, the beliefs they can adopt, or the actions they can attempt to perform. Agents are creative beings; it is just that their creativity occurs in a given social context that influences it (ibid., p.67)



Hence, even if Foucauldian discourse theory does contest the existence of an autonomous subject outside of discourse, the individual still has agency. As Bevir further suggests, such an understanding of a subject that constitutes themselves within social contexts is in line with the more recent work of Foucault, particularly his writings on governmentality (Foucault, 1991a) underlying this thesis. Combining this perspective with a genealogy (see above) includes analysing who was conceived of as a subject at a particular point in time, how this subjectivity has been formed, and what has determined it. For example, the ratification of the United Nations Convention on the Rights of the Child (1989) has, in many countries, led to the formation of a certain subjectivity in children (Kerber-Ganse, 2009; Liebel, 2008). Children are now, in many contexts, themselves considered as rights holders.

It has been argued that participatory methods in the new social studies of childhood have a tendency to be preoccupied with the proximate material environment of children's lives (such as playgrounds and living rooms), while at the same time ignoring structural processes and abstract, complex themes (Ansell, 2009, p. 193). For example, while participatory approaches with children, such as painting and photography, maximise their agency, they also tend to ignore larger structural themes, including economic globalisation, advanced liberal policies, and the migration of psychiatric diagnoses around the globe. As Philo (2000) suggests, rather than limiting enquiries to the 'agency-based geographies of childhood behaviour', research should also tackle

the macro-scale, structure-based geographies of childhood as shaped by broad-brush political-economic and social-cultural transformations (ibid., p.253)

Against this backdrop Foucauldian Genealogical Discourse Analysis offers a way to overcome the preoccupation with the proximate material environment through problematising the wider social, political and cultural context of processes that are shaping the lives of children and adults.

## **Challenging Taken for Granted Assumptions**

Generally, Foucauldian Discourse Analysis enables researchers to explore how discursive practices have established things the way they are, why they remain that way, and what alternative conceptualisations of these things might have been established instead. It problematises commonly accepted and deployed assumptions through a genealogical exploration of practices that have been thought of as being self-evident (Dean, 2010). In other words, 'what is produced in such investigations is a shattering of conventional thought that strikes at the heart of our most taken-for-granted motivations' (Barry et al., 1996, p. 6). Foucauldian Discourse Analysis therefore 'offers the potential to challenge ways of thinking about aspects of reality that have come to be viewed as being natural or normal' (Cheek, 2008, p. 355).

To exemplify this, in previous research (Rudin, 2011b), I argued that while contemporary discourses render institutional care of children problematic through reference to taken-for-granted and culturally insensitive ideas of 'universal developmentalism', the recourse to transnational adoption to reintegrate children into families is not self-explanatory. Rather, through discursive practices, Ghana (and much of the majority world), in the light of changes in the global economy of adoption, has been portrayed as an ignorant and underdeveloped nation state in need of help and assistance. This, in turn, led to the revival of the image of the rescuable orphan abroad that sought to create an 'ideology of rescue' during the 1940s-1960s (Briggs, 2003, p. 180).

The next section elaborates on the type of data collected for this research, briefly contextualises that data and explains how it was collected.

## **Data Collection**

My collection of data was foremost driven by the research questions that I outlined at the beginning of this chapter. More specifically, the questions of how children labelled with ADHD are (i) rendered knowable and governable, (ii) conceptualised and represented, and (iii) governed towards specific ends

drove my data collection. The next sections will elaborate upon the process of data collection and its relationship to data analysis in more depth.

## **Introduction**

As mentioned above, my approach is most closely aligned with what Carabine (2001) has termed Foucauldian Genealogical Discourse Analysis. Carabine offers some guidance on how to approach such an analysis. As a starting point, possible sources of data have to be identified. As a rather deductive approach, a genealogical approach emphasises the use of existing texts. In order to collect data for this analysis I focused on three broad sources of existing texts:

- (i) mass media communications
- (ii) publications of the parent advocacy group Elpos
- (iii) parliamentary debates and reports

Drawing on a variety of data sources aims to increase the variability across data, an important concern within discursive approaches (Potter and Wetherell, 1987). I have taken up this concern by including data from newspaper archives, parliamentary databases, printed materials and presentations.

Data collection, though, was not a distinct part that was finished before data analysis started. Glaser and Strauss (2009) suggest continuing data collection throughout the research process. It is this approach to theoretical sampling that has been adopted in my thesis. Emerging themes, therefore, informed the identification and collection of further data. Under such an approach data collection is never completely excluded from the process, as emerging themes may require further data collection or re-examination of already collected data to allow a more in-depth analysis. I will elaborate upon this in some more depth later in this chapter, under the heading Data Analysis, and now go on to briefly introduce the data sources of this research.

## **Mass Media Communications**

The largest part of my data consists of mass media communications. In July 2017 I started to map the media landscape in Switzerland by identifying the largest newspapers in terms of circulation and subscriptions. According to the Swiss Association of Media (Schweizer Medien, 2016), the national newspapers *Neue Zürcher Zeitung*, *Tages-Anzeiger*, *Blick* and *20 Minuten* are the largest ones in German speaking Switzerland. To account for the cultural variety within Switzerland I have also included the newspapers *24 Heures* and *20 Minutes* in the French language, as well as the newspaper *20 Minuti* in the Italian language (a brief review of these newspapers is covered in **Appendix A**, p.346). The selection of these newspapers accounts for the distribution of languages in Switzerland. In the 2017 census 62.6% of the population of Switzerland reported German as their mother tongue, while French accounted for 22.9% and Italian for 8.2% of the population (Bundesamt für Statistik, 2019). Spoken by less than 1% (ibid.), Romansh, although an official language, is a rather marginalised language in Switzerland and there are no newspapers published in this language that could be included as data in this thesis. Equally, all non-official languages, which constitute together less than 6% of the overall share of languages, are not covered in this analysis as they do not relate to a distinct language region of Switzerland.

## **Article Coverage**

In order to identify those articles of interest to this study, I used the search terms 'ADHD' (abbreviation for attention deficit hyperactivity disorder), 'ADD' (abbreviation for attention deficit disorder) and Ritalin, in both their full text as well as in their abbreviations and in all three languages described above. Ritalin has now almost become a synonym for ADHD (Miles, 2012), and the effects of Methylphenidate (the chemical basis of Ritalin) are being used to legitimise a diagnosis *ex juvantibus* (Hasler, 2013; Leuzinger-Bohleber et al., 2006; Schmidt, 2019). The search in the newspaper archives thus aimed to

render visible the use of this terminology throughout the discourse. The following table lists all search terms used in the different languages:

Search Term	Used in
ADHS (abbreviation for 'Aufmerksamkeitsdefizit-/Hyperaktivitätsstörung')	German
ADS (abbreviation for 'Aufmerksamkeitsdefizitstörung')	German
TDAH (abbreviation for 'Trouble du Déficit de l'Attention avec Hyperactivité')	French
TDA (abbreviation for 'Trouble du Déficit de l'Attention')	French
ADHD (abbreviation for 'Disturbo da deficit di attenzione/iperattività')	Italian
Disturbo da deficit di attenzione	Italian
Iperattività	Italian
Ritalin	German, Italian
Ritaline	French

Table 1: Search terms

It is worth noting that in all three languages there were occasions where the English terminology 'ADHD' had been used rather than the translated version in the newspaper's language. I have consequently used both 'ADHD', 'ADD' and the relevant language of the newspaper in the searches. Furthermore, in Italian the abbreviation to 'Disturbo da deficit di attenzione/iperattività' seems to be the English equivalent. I have thus used both 'ADHD', 'ADD', 'Disturbo da deficit di attenzione', and 'Iperattività' to collect articles reporting on the phenomenon of Attention Deficit Hyperactivity Disorder.

The selected date range for the search was as far back as the archives allowed. For German articles, the search covered articles as far back as 1780 (archives of Neue Zürcher Zeitung); for articles published in French, the search range dated back to 1762 (archives of 24 Heures). Italian articles were covered back to 2011 (archives of 20 Minuti). The first article that appeared in all these searches that mentioned Ritalin in relation to children was published in March 2000 by Neue Zürcher Zeitung (Weidmann, 2000). Hence, this work covers two decades of articles, 2000-2019. This reflects well the 'discursive event' (see 'the structure of discourses later in this chapter) of the MTA study (MTA Cooperative Group, 1999), which arguably

led to the replacement of the concept of Psycho Organic Syndrome by 'ADHD'.

### Overview of Media Data

The following table provides an overview of the collected items. These include articles (the large majority), letters to the author and announcements. In total, 1139 items were collected.

Newspaper	Items	Discarded	Selected
24 Heures	48	22	26
20 Minuten	171	103	68
20 Minutes	40	24	16
20 Minuti	28	15	13
Blick	95	47	48
Neue Zürcher Zeitung	292	137	155
Tagesanzeiger	465	170	295
<b>Total</b>	<b>1139</b>	<b>518</b>	<b>621</b>

Table 2: Overview of collected newspaper items

Those items that did not relate to children but rather to ADHD in adults or the (illicit) use of Ritalin by adults were discarded before any further analysis took place. Arguably, these items were, to a certain extent, shaped by the political orientation of the newspaper that published them. In his account of the most influential newspapers in Switzerland, Blum (2004) mapped the 34 biggest newspapers on the political landscape of Switzerland (see also **Appendix A: Newspapers Used for Data Collection**, p.346). Many print media explicitly mention their orientation in their mission statement. Otherwise, however, it is the editorial staff who determine the political position through their comments, voting recommendations, campaigns and theme selections.

Blum argues that due to the lack of scientific research into this, the classification of the political orientation of newspapers should be considered with caution (ibid.). Moreover, he suggests that the classifications are indicative rather than fixed for three reasons. Firstly, there are media that do not follow a clear course. They rarely take a clear stand. This is the case with some newspapers that have a monopoly position in their region, but also with

those that do not see themselves primarily as political. Secondly, there are media that hardly comment and where the tendency must be determined indirectly by the choice of topic. Finally, there are media whose tendency has changed recently due to a change in their leadership. Blum suggests that the greatest power lies with the left-liberal media. They outweigh those of the centre and even more the right-wing liberals. Only a few journals position themselves on the more extreme positions of left and right.

### Visual Data

All of the newspapers used images in their articles. Not surprisingly, though, those that are published in tabloid format used more images than those published in other formats. The following table shows how many images were published in relation to the number of items collected.

Newspaper	Selected Items	Images	Percentage
24 Heures	26	7	27
20 Minuten	68	31	46
20 Minutes	16	7	44
20 Minuti	13	5	38
Blick	48	27	56
Neue Zürcher Zeitung	155	32	21
Tagesanzeiger	295	87	29
<b>Total</b>	<b>621</b>	<b>171</b>	<b>28</b>

Table 3: Overview of selected newspaper items and visual data

### Parent Advocacy Association ‘Elpos’

As mentioned in the literature review, advocacy groups have been identified as being amongst the central drivers of the popularisation of ADHD (cf. **Consumerism and Advocacy Groups**, p.42). In Switzerland, the parent advocacy group Elpos is well known for its awareness-raising campaigns. Data collection focused on information available on the website (Elpos, n.d.), on its main publications, and on its media presence. Its main publications are published in journal format. These are organised around three themes related to ADHD: general introduction to the diagnosis (Elpos, 2016a), education (Elpos, 2016b) and therapeutic interventions (Elpos, 2016c). The

contributions are predominantly from members of the psy-complex (Rose, 1999), i.e. psychologists, psychiatrists and paediatricians, with a few exemptions, including accounts by parents.

## Parliamentary Database

Data collection took place using the Curia Vista Database of parliamentary proceedings (The Swiss Parliament, n.d.). This database contains details of items of business of Parliament (a brief introduction to the Swiss Parliament may be found in **Appendix B**, p.350), covering all sessions from winter 1995 to date. Cura Vista records parliamentary events and items, including procedural requests, elections, petitions, motions and Federal Council dispatches.

I have searched the database using the same search terms as for the media database (see above). A total of 36 database entries (as per 20 February 2020) were identified:

Instrument (English)	Instrument (German)	Quantity
Query	Anfrage	4
Interpellation	Interpellation	11
Question Time	Fragestunde	5
Motion	Motion	16
Postulate	Postulat	5
Initiative	Initiative	1
	<b>Total</b>	<b>42</b>

Table 4: Political enquiries regarding Ritalin use and ADHD in Switzerland

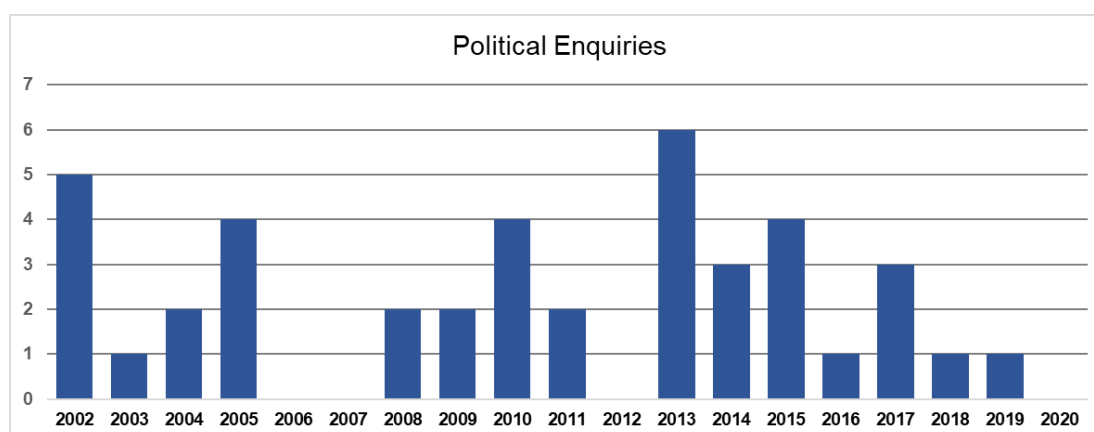


Figure 1: Political enquiries across time



The use of these different parliamentary instruments over a period of almost two decades (see the Figure above) documents the ongoing controversies in the parliament around 'ADHD' in children and its treatment with Ritalin. There are two peaks (2002 and 2013), while the trend from 2013 onwards indicates a decline in activity level. The earliest intervention was an interpellation submitted by Christiane Brunner, a member of the Social Democratic Party (SP) on 11 June 2002. It may be argued here that this points to the early beginnings of a counter discourse following the discursive event of the publication of the MTA study (MTA Cooperative Group, 1999). A total of 214 pages of parliamentary discussions have been collected, as well as two reports: the so called *Expert Report* (Eckhardt, 2014) and the subsequent report of the Swiss Federal Council (2014). These reports were produced as a reaction to what may be called the counter-discourse on ADHD and the use of stimulants in children.

## **Further Data Sources**

As described above, data collection was not a one-time process. Rather, the theoretical sampling was based on an iterative process (I will elaborate upon this in some more depth later in this chapter under the heading Data Analysis). Emerging topics led to the collection of further data, and that data in turn led to the emergence of further (sub)topics. In some instances further data sources were also directly referred to in the data analysed.

Significant documents that were collected after the first round of data collection in 2017 include the *German Guideline on ADHD* (DGKJP et al., 2018a) and the report on its production process (DGKJP et al., 2018b). The *German Guideline on ADHD* was discussed in some of the media articles that were collected during an updated round of data collection in 2018. I analyse this guideline in more depth in the next chapter, particularly in terms of the way it treats knowledge and how it has been produced through discursive practices.

Moreover, a children's book published by Novartis and titled *Octopus Hippihopp. How Attention Deficit Syndrome (ADD) was Explained to the Octopus* (title translated from German, Albrecht, 2001) was identified during the analysis of the parliamentary discourse. This is a good example of how the pharmaceutical industry has found communication channels that are not affected by the prohibition of direct-to-consumer advertisements in Switzerland.

The analysis of the media discourse also brought to the fore parliamentary discussions on the cantonal level. As I restricted the first round of data collection to the federal level, cantonal level discourses were only covered indirectly. Worth noting is the draft of the proposed new education law in the canton of Basel-Country, which sought to disempower parents regarding diagnostics and therapeutic interventions in their children (Cantonal Parliament of Basel-Country, 2018). I will discuss this in Chapter Six (cf. **From Mother Blaming to Forced Screening and Drugging**, p.239). The next section now attends to how I analysed the data.

## **Data Analysis**

### **Noticing, Collecting and Thinking**

Seidel (1998) describes data analysis as a symphony of noticing, collecting and thinking. As these terms are not self-explanatory I will briefly introduce them here and then elaborate further on each of them in relation to my process of data analysis. Firstly, noticing includes, on a general level, the collection of data, including gathering documents as described above. This is then followed by reading the data. The things a researcher is noticing while reading are then coded. Secondly, collecting means sorting the coded data according to emerging and identified themes. Thirdly, thinking refers to the process of examining the collected things to identify patterns and relationships between and across collections.

Following this approach I started to code my data after the first round of data collection (see above). To facilitate the analysis I imported all collected texts into the qualitative analysis software NVivo and then started to carefully read all my data. Reading and re-reading led to a certain familiarity with my corpus of data, a process Carabine (2001) emphasises as a precondition for any further analytical steps. During this familiarisation process I was impressed by the visual data used throughout the discourse, particularly in the mass media. I therefore decided to code the visual material before coding any other material. However, this first round of coding was facilitated outside of the analysis software. Rather than coding the images within the confinements of NVivo, I decided to print them out. The following photo shows the images arranged on a pinboard after several rounds of coding:

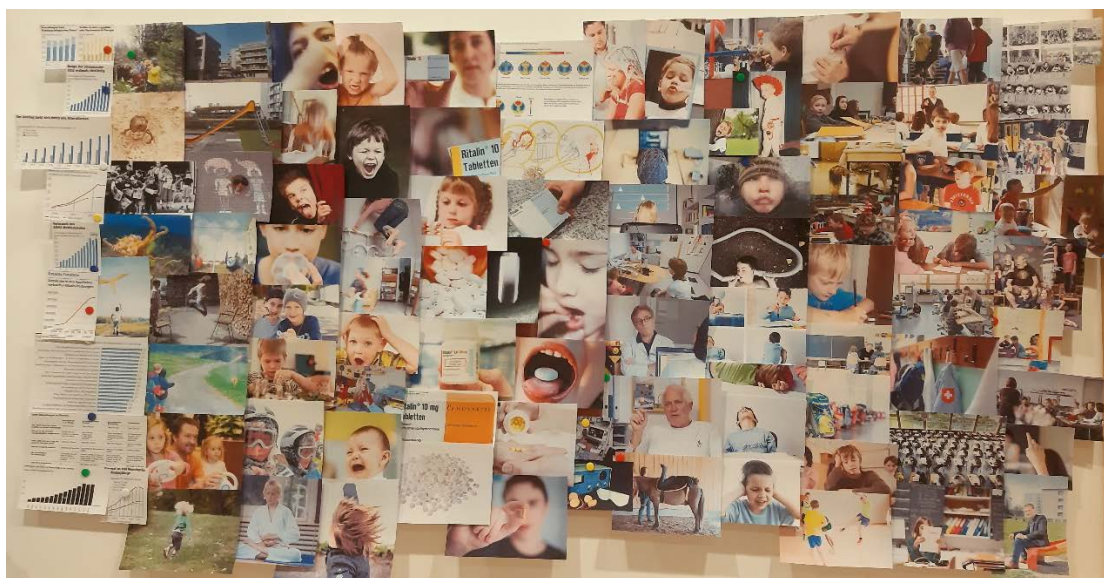


Figure 2: Image analysis

This allowed a much more creative process of coding and recoding them while keeping the overview of the full set of visual materials. The first step of analysis, consequently, involved quite literally what Jorgensen described as ‘a breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units’ (1989, p. 107). These pictorial elements were then sorted and coded according to emerging themes.

In a next step I grouped the emerging themes into three umbrella themes, which in turn formed the topics of the three findings chapters of this research. As Seidel argues, such themes may be used as 'heuristic tools' that 'facilitate discovery and further investigation of the data' (Seidel, 1998, p. E3). In the context of my thesis, this included going back to the full body of collected data. Using the themes that I had identified in the visual data as flags pointing to other things in the data helped me to organise and reorganise my data. Through opening up the data these themes laid the ground for a more detailed analysis.

In these further steps of analysis, additional subthemes emerged and shaped the use of the themes identified in the process of visual analysis. As Seidel suggests, this process may be, to some extent, analogous to working on a jigsaw puzzle. Collecting things, thus, means that after the data has broken down into pieces,

the researcher sorts and sifts them, searching for types, classes, sequences, processes, patterns or wholes. The aim of this process is to assemble or reconstruct the data in a meaningful or comprehensible fashion (Jorgensen, 1989, p. 107)

Finally, thinking about things is the process of examining the instances that have been collected. This included comparing and contrasting each of the themes to discover similarities and differences, to identify sequences and patterns, and to find gaps in the data. This step in the process also included alternating between the fragmented, coded data and the full dataset. Referring regularly to the 'whole' of the data prevented me from becoming misled and distorted by data fragments. The approach I chose accordingly was iterative rather than linear:

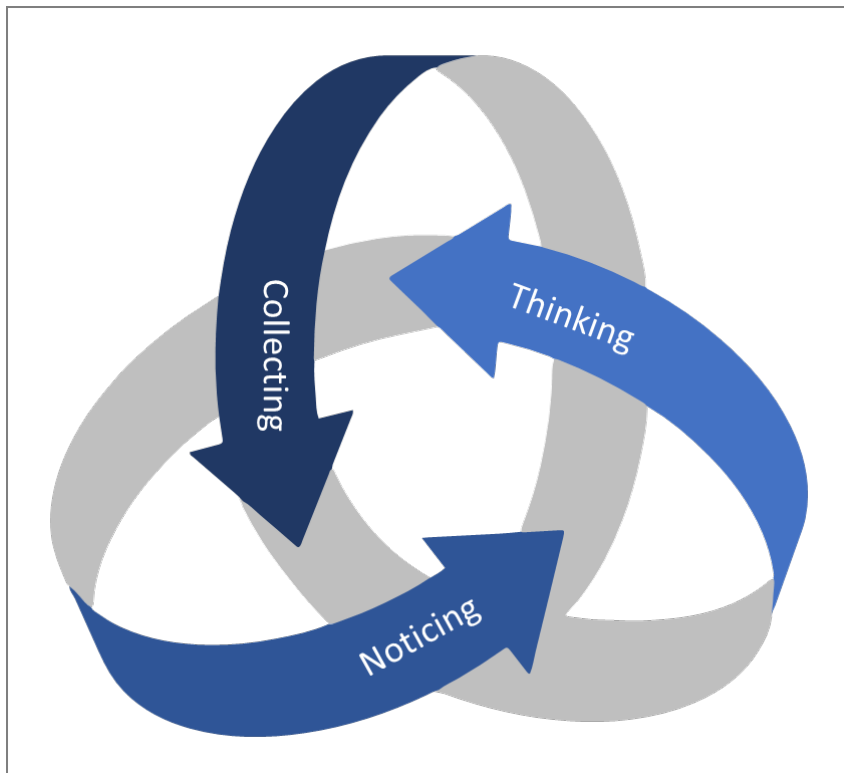


Figure 3: Iterative process of Noticing, Collecting and Thinking, adapted from Seidel (1998)

Additionally, Seidel (1998) argues that qualitative data analysis tends to be holographic in that each step contains the whole process. For example, while I was conducting the first round of data collection I was already mentally thinking about emerging themes.

When analysing discourses some generic terminology might be a helpful tool in facilitating the analysis. It is this terminology that I now turn to.

## The Structure of Discourses

Jäger and Maier (2010) offer some generic terminology and tools in order to render the structure of discourses more visible and amenable to analysis. They distinguish, in a useful way, the following characteristics of discourses:

- *Special discourses*: refers to discourses in the sciences, as distinct from non-scientific discourses, which are termed interdiscourses. Elements of special discourses constantly shape interdiscourse

- *Discourse strands*: designates flows of discourse that centre on a common topic. Each discourse strand comprises a synchronic and a diachronic dimension. A synchronic analysis of a discourse strand examines the limits of discourses at a given time, while a diachronic analysis may be used to reveal the genealogy of a certain discourse.
- *Discursive limits*: each discourse consists of statements that are sayable and simultaneously inhibit other statements that are not sayable. The borders to the latter are called discursive limits. Through rhetorical strategies such as defamations, relativisations and allusions, discursive limits can be extended or narrowed down
- *Discourse fragments*: are constitutive elements of a particular discourse on the same topic. These fragments are, in discourse analytic approaches, often called texts. But since one text may contain various discourse fragments, the term discourse fragment is more precise.
- *Discursive knots*: texts usually refer to various topics and, consequently, to various discourse strands. Statements containing entangled discourses are called discursive knots.
- *Collective symbols*: also called 'topoi', are cultural stereotypes. They designate an important way to link together discourse strands. Collective symbols are a means to 'interpret reality, and have reality interpreted for us, especially by the media' (Jäger and Maier, 2010, p. 48). They may be connected together in order to amplify the power of discourses. The technique of connecting collective symbols is called *catathresis*.
- *Discourse planes*: are the social locations from which speaking takes place, such as the sciences, the media, politics and education. Different discourse strands may operate on different discourse planes.
- *Discursive events*: influence the development of discourse through the intense use of the discursive planes of politics and the media over a longer period of time. Whether an event becomes a discursive event

or not hence depends on the power relations at work in politics and the media.

- *Discourse positions*: describes the ideological position from which individuals, groups and institutions participate in and evaluate discourses. Subjectivity is neither natural nor obvious but established through discourse. Subjects are enmeshed in discourses and work them into a particular ideological position. Within a dominant discourse ideological positions are fairly homogeneous. This homogeneity is not naturally given but an effect of the power relations within a certain discourse.
- *Global discourse*: a global discourse designates the very complex network of overall societal discourses. Even though global discourses are rather heterogeneous, they tend to have homogeneous patterns.
- *History, present and future of discourse*: As Foucault has pointed out, the analysis of longer periods of time allows the reconstruction of the genealogy or archaeology of a particular discourse strand. Such a genealogy may be used to produce prognoses about a discourse. However, the analysis of overall or even global discourses is an enormous endeavour and only feasible through breaking it down into many single projects.

After introducing this helpful terminology regarding the structure of discourses, let us now consider some analytic strategies that facilitated the analysis of the discourse on childhood ADHD in Switzerland.

## **Analytic Strategies**

The analysis was foremost informed by a dimensional approach that has been developed within the interdisciplinary field of what may be termed Foucauldian genealogical approaches (Barry et al., 1996; Carabine, 2001; Dean, 2010; Foucault, 1991a; Rose and Miller, 1992) and the sociology of scientific knowledge (Fleck, 1979; Kuhn, 1996). In particular, the analysis was inspired by four analytical dimensions that have been developed by other scholars in what is often referred to as governmentality (Foucault,

1991a), which focuses on how discourses aim to govern subjects towards specific ends. Similar dimensional approaches (although with a stronger emphasis on subjectification processes) have been proposed in Discursive Psychology (see, for example, Arribas-Ayllon and Walkerdine, 2013). Furthermore, this thesis is inspired by concepts of ‘thought style’ and ‘thought collective’ that have been put forward by Fleck (1979). It is these dimensions and concepts I now briefly introduce throughout the next few sections.

### **Visual and Spatial Aspects of Discourses**

The first analytical dimension is concerned with the visual and spatial aspects of discourses. As Dean (2010) proposes, there are many ways of visualising fields we aim to govern, including tables, graphs, maps, architectural drawings and images. They provide a visual way into

who and what is to be governed, how relations of authority and obedience are constituted in space, how different locales and agents are to be connected with one another, what problems are to be solved and what objectives are to be sought (ibid., p.41)

This perspective, consequently, includes paying attention to the visual and spatial dimensions of governing children and families and examining ‘diagrams of power and authority’ (ibid., p.41). As Dean argues, such an analysis can shed light on how regimes of practices are dependent on specific types of spatiality and visibility. For example, clinical practices in medicine seek to render the individual body visible in depth, while the panoptical gaze (Foucault, 1989) in schools is concerned with the spatial distribution of individual bodies in the classroom. Moreover, discussion about the use of social space autonomously has led to concerns regarding children both being at risk and being risky (McNamee, 2016). Risk-management strategies are thus concerned with the visibility and inspectability of social space as a means of preventing delinquency.

### **Rationalities Embodied in Discourses**

The second analytical dimension is concerned with knowledges embodied in discourses. As Rose and Miller (1992, p. 178) point out, politics is a



discourse plane where both articulation and justification of idealised ways of representing reality in the light of specific knowledges takes place. Such rationalities concern the

changing discursive fields within which the exercise of power is conceptualized, the moral justifications for particular ways of exercising power by diverse authorities, notions of the appropriate forms, objects and limits of politics, and conceptions of the proper distribution of tasks among secular, spiritual, military and familial sectors (ibid., p.175)

Despite the heterogeneous character of such discourses, there are certain regularities that can be discerned within them. First, rationalities have an epistemological aspect. They are formulated with reference to specific knowledge and expertise, and they embody certain conceptualisations of those they aim to govern. To give an example, schoolchildren are being understood within a complex body of knowledges, including medicine, pedagogics, (school) social work and psychology. These understandings, accordingly, both foster and rely upon knowledge and expertise, and define adequate ways of governing children. As Foucault notes in his *Archaeology of Knowledge* (2002), these rationalities hence are the foundation of discourses since they enable a particular discourse 'to speak of this or that object, in order to deal with them, name them, analyse them, classify them, explain them, etc.' (2002, p. 42). Such forms of knowledge also define those authorized to make truth claims about children and families. Government, thus, positively depends on language that is able to render reality amenable to political intervention. It is important to note that language used in (political) discourse is not passive or simply rhetoric. Rather, it should be understood as 'a kind of intellectual machinery or apparatus for rendering reality thinkable in such a way that it is amenable to political deliberations' (Rose and Miller, 1992, p. 179).

Second, political rationalities have a characteristically moral form. In other words, these rationalities include ideas towards which efforts of government should be aimed at, such as equality, justice, freedom, efficiency etc. (Rose and Miller, 1992). An analysis of such discourses, then, is concerned with the

way that certain practices depend on experts, authorities, as well as specific regimes of truth. In other words, it analyses

what counts as truth, who has the power to define truth, the role of different authorities of truth, and the epistemological, institutional and technical conditions for the production and circulation of truths (Rose 1999: 30)

What is at stake here is that the very act of governing is only possible within the context of ideas of morality and legitimacy that define the ethics of government.

The third concern with the rationality of discourses is with their problematising activity. Government, in this understanding, tends to frame issues to be addressed as problems and defines solutions to them (Dean, 2010; Inda, 2005; Rose and Miller, 1992). Problematisations are generally formulated around certain realms of experience or events, such as poverty, school performance, deviancy, epidemics and economic downturns. They seek to formulate the nature of these realms and to propose ways to govern them towards specific ends. Analysing discourses with a focus on this dimension hence tends to explore how certain phenomena are being articulated as problems, investigates various ways governmental authorities, such as social workers, teachers, psychiatrists etc, tend to classify certain experiences or behaviour as problematic, and to scrutinise the complex sites in which these formulated problematisations are given form. In other words, such an analysis tries to reveal the complex ways in which the government of children is bound to an ongoing problematisation and classification of their behaviour. As Arribas-Ayllon and Walkerdine (2013, p. 99) emphasise, problematisations serve both methodological and epistemological purposes, as they allow the researcher to 'trace how discursive objects are constituted and governed' and to critically position oneself in relation to research.

### **The Cultivation of Subjectivities through Discourses**

The last dimension is concerned with the subjects of government, that is with the individual and collective identities discourses aim to cultivate. The concern with the subjects of government reveals itself best when focusing on

two distinct levels. The first level is concerned with how regimes of practice seek to cultivate particular types of identity, both in individuals and populations. In addition, it draws attention to the forms of agency and subjectivity being sought in the subjects of government. The concern here, therefore, is to render visible how discourses seek to form modern subjects, such as schoolchildren, through attaching them to particular identities. Drawing on Maffesoli (1991), Mitchel Dean (2010) argues that much of the problem in this context is thus one of 'identification' rather than of 'identity'. The significance of this process lies in the way that government seeks to alter human conduct through attaching individuals to particular identities and linking them with specific qualities and capacities. To follow up on the example of schoolchildren, such subject making seeks to foster particular identities through getting these children to experience themselves as schoolchildren who bear certain rights but also duties.

However, even when government seeks to cultivate particular identities and forms of agency, it does not mean that it is always successful. Hence the other concern along this line is to shed light on how particular subjects embrace, adapt or even refuse these identities (Inda, 2005). Significantly, regimes of practice do not determine subjectivity, but they 'elicit, promote, facilitate, foster and attribute various capacities, qualities and statuses to particular agents' (Dean, 2010, p. 43). Consequently, even if discourses seek to align individuals and populations with certain identities in order to amend their conduct and to increase welfare, these individuals may still negotiate those processes to which they become subjected. As an example, people may challenge the idea of sexuality and identity and ask for a more diversified approach to the use of such qualities, capacities and statuses.

### **Technical Aspects of Discourses**

The third dimension is concerned with what Dean (1995) calls the 'techne', which is the technical aspect of modern government. It draws attention to the procedures, tactics, techniques, technologies and mechanisms through which authority is being constituted. The technological reveals itself in the set

of instruments and techniques that 'endeavours to translate thought into practice and thus actualize political reasons' (Inda, 2005, p. 9). Governing children and families, consequently, depends on technical means that, through their pragmatic form, often limit what is possible to do. For instance, the revision of school reform will also depend on the resources available. Inda (2005) suggests to elaborate upon the *techne* of government in two ways.

The first way draws attention to the technical instruments used in order to make children visible and render their lives into programmable forms. These technical instruments encompass things like

techniques of notation, computation and calculation; procedures of examination and assessment; the invention of devices such as surveys and presentational forms such as tables; the standardisation of systems for training and the inculcation of habits; the inauguration of professional specialisms and vocabularies; building designs and architectural forms (Rose and Miller, 1992, p. 183)

The list of such technical instruments may obviously be expanded a lot, as its heterogeneous elements are, in principle, infinite. Of particular importance here are what Bruno Latour (1986) termed 'inscription devices', referring to the material conditions that enable thought to work upon reality. As Foucault (1980) mentioned in his lecture on governmentality, eighteenth-century Europe articulated a certain notion of statistics, a 'science of state', as a way to accumulate, tabulate and present information on those to be governed. Governing children and families, accordingly, both inspires and depends upon such inscription devices to render reality in a calculable form. In other words, these accumulations and representations of information in the form of surveys, reports, statistics, charts, pamphlets, guidelines and the like render children visible and allow the formulation of problematisations and their corresponding solutions. As Rose and Miller (1992, p. 185) suggest, through these devices, 'reality is made stable' and rendered in a way to make comparison, diagnosis and debate of certain phenomena feasible. Yet, such inscriptions are not the outcome of a neutral form of data accumulation. Rather, these material inscriptions designate a form of action themselves.

They intend to represent those to be governed in a certain way, in order to devise ways to achieve desired ends. An analysis of discourse, adopting this dimension, hence draws attention to the importance of the technical aspect of directing the conduct of children.

The second concern with the 'techne' relates to programmes of government. Government, in this understanding, assumes that the reality can be 'programmed'. Such programmes manifest themselves in the

realm of designs put forward by philosophers, political economists, physiocrats and philanthropists, government reports, committees of inquiry, White Papers, proposals and counterproposals by organizations of business, labor, finance, charities and professionals, that seek to configure specific locales and relations in ways thought desirable (Rose and Miller, 1992, p. 181)

Programmes, therefore, may be understood as 'relatively systematic forms of thought' (Dean, 2010, p. 32) that are aimed at changing certain practices of government. To act upon the hopes, desires, aspirations and needs of individuals and populations, consequently, requires investing in programmes that seek to reform certain regimes of practices. Analysing discourse, then, seeks to understand the operation of a regime of practice by examining how such programmes are problematising regimes of practice in order to construct its intrinsic logic.

The logic or strategy of a regime of practice, however, can be quite different from that of the programmes that aim to transform them towards specific ends. As Dean puts it,

the critical purchase of an analytics of government often stems from the disjunction between the explicit, calculated and programmatic rationality and the non-subjective intentionality that can be constructed through analysis (Dean, 2010, p. 32).

The programmatic aspect of government, thus, reveals itself in the way 'how specific programs go about shaping the environment and circumstances of specific actors in order to modify their conduct' (Inda, 2005, p. 10) as a means to achieve desired ends.

## **Thought Style and Thought Collective**

Examining epistemologies in both historical and archaeological terms renders visible how episodes of thinking are subjected to change. The ways of thinking and conducting science at particular times throughout history has been theorised by Thomas Kuhn (1996) as 'paradigms'. Kuhn proposes that such ways of thinking are fixed within a particular episode, and that major shifts in thinking should accordingly be considered 'revolutions'. Building on Hacking (1990), Wastell and White (2017), though, argue that Kuhn's work does not offer any insights into the role of social interaction in scientific communities in the production of such paradigms and revolutions. But they argue that these concerns are well addressed by the seminal work of Ludwig Fleck (1979, 1935). In his account of comparative epistemology Fleck elaborates on the social nature of scientific knowledge production. In particular, he proposes that new research is significantly constrained by prior practices and discoveries. He called this shared framework of beliefs and values a 'thought style', and the community of researchers drawing upon it a 'thought collective'. Fleck suggests thinking of a thought collective as a structure that consists of a small esoteric circle and a larger exoteric circle. The following graphic visualises these circles:

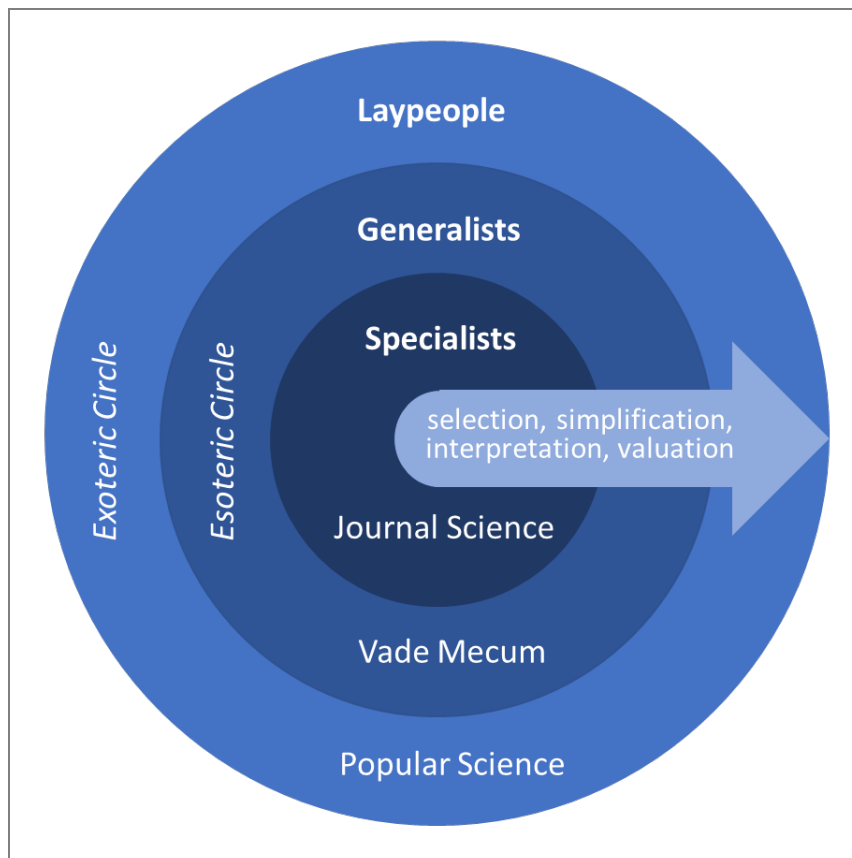


Figure 4: Esoteric and exoteric circle, adapted from Lima et al. (2018)

The smaller esoteric circle consists of an inner sphere of special experts and an outer circle of general ones. Expert science, in this model, consists of both vade mecum and journal science. The latter comprises contributions of specialist experts that are published in academic journals. Such accounts are always provisional, indicative and personal, as they encompass various points of view and working methods. As Fleck (1979) suggests, the translation of such often contradicting and incongruent findings across journal articles into vade mecum science is not a simple process:

[o]nly through the sociocognitive migration of fragments of personal knowledge within the esoteric circle, combined with feedback [*Rückwirkung*] from the exoteric circle, are these fragments altered so that additive, impersonal parts can arise from the nonadditive personal ones (ibid, p.118, emphasis in original)

Only in impersonal vade mecum science are absolute claims such as ‘this exists’ to be found, which are constructed through ‘selection and orderly

arrangement' of individual contributions. Crucially, the plan guiding selection and arrangement processes in the construction of vade mecum science 'will then provide the guidelines for future research' (ibid., p.119) and hence both direct and limit future findings. This plan therefore

governs the decision on what counts as a basic concept, what methods should be accepted, which research directions appear most promising, which scientists should be selected for prominent positions and which should simply be consigned to oblivion. Such a plan originates through esoteric communication of thought - during discussion among the experts, through mutual agreement... (ibid., p.120)

Vade mecum science is then further translated into popular science by omitting details and, in particular, controversial opinions. Such 'simplified, lucid and apodictic science' produces an 'artificial simplification' that 'furnishes the major portion of every person's knowledge' (ibid, p.112). Even the most specialised expert, Fleck suggests, owes many comparisons, concepts and even their general point of view to such popular sciences.

A 'scientific fact', consequently, is a conceptual relation that is determined by the thought style of a certain thought collective. As Fleck argues, 'if such a fact is taken to mean something fixed and proven' then it cannot exist in specialised journal science but only in vade mecum science (ibid, p.124). The factuality of such relations thus aims to maximise thought constraint, and to render 'truth' into 'an objectively existing quality' in vade mecum science, which then takes the form of 'something holy or self-evident' in popular science (ibid, p.116ff). For instance, the thought style of developmentalism that I have discussed in the previous chapter (cf. **Developmentalism**, p.19) suggests that children grow up according to predefined patterns. Ignoring complexities and contradictions around this idea popular science presents this as self-evident. Arguably, this idea significantly shapes the way we currently understand how children grow up.

## **Translation of non-English Data**

As I have mentioned in the introduction, all data analysed are in a language other than English. I read and coded data in German, French and Italian, and



then translated part of that data into English to present it throughout this thesis. During the first round of noticing (i.e. collecting, reading and coding data, see above), I identified the German texts as the most comprehensive body of data. Interestingly, lower prevalence rates of ADHD in the French, and particularly in the Italian speaking part of Switzerland (cf. **The Cultural and Political Dimension of Deviance**, p.171), do not correspond with a more sophisticated counter-discourse. Rather, there is generally less discussion about and therefore less popularisation of the concept of childhood ADHD in these cultural regions. Consequently, all presented data was translated from the German body of data only.

As van Nes et al. (2010, p. 313) argue, 'interpretation of meaning is at the core of qualitative research', and translation is an 'interpretive act' too. Being both the researcher and translator of this project, I therefore had to interpret meaning in the relevant source language and then translate it into English. While interpreting and representing meaning is challenging per se, these are complicated in the context of cross-cultural, interlingual translation (ibid.). For example, texts may contain metaphors that are language-specific and bound to a certain cultural context (Lakoff and Johnson, 2003).

Furthermore, there may be culture-specific differences in the way people think about and describe the world around them. For example, in German it seems to be rather common to refer to a specific child as 'it'. Acknowledging that this sounds rather odd in English, it also potentially undermines children's status as subjects, and reinforces problematic power relations between children and adults, I have replaced these instances in quoted texts with [they]. Singular 'they' (and its further forms 'them', 'their', 'theirs' and 'themselves') is officially endorsed by the American Psychological Association's APA Style (APA, 2019) 'because it is inclusive of all people and helps writers avoid making assumptions about gender'. It avoids the binary that, for instance, the use of 'him/her' would express and is decidedly inclusive of all gender identities and expressions. Aiming to be consistent, I have used singular 'they' throughout.

To enhance the validity of cross-cultural and multi-lingual qualitative research and to reduce potential loss of meaning, van Nes et al. (2010) suggest to stay in the original language as long in the research process as possible. Following this advice, I didn't translate all my data, but only those texts that I decided to present in this thesis. This way, I was able to stay withing the original language, to think in that language while coding (which is particularly true for German), and to prevent any early loss of meaning at this stage. Furthermore, I followed the advice of van Nes et al. (ibid.) to use flexible rather than fixed translations for as long as possible, and to see myself as a moderator in the translation process. This approach allowed me to acknowledge that different translations may be linguistically correct, but that they may have subtle differences in meaning. For example, I discussed the issue around referring to a specific child as 'it' (see above) with my supervisors and other scholars in the field, and then decided upon the use of singular 'they' instead. Also, due to my limited ability of reading and understanding Italian texts, I discussed my understandings of this body of data with other researchers. These informal exchanges helped me to understand those Italian texts more accurately, and to account for culture-specific aspects of language use.

Finally, where translations of specific words have been challenging, I have indicated this by presenting the term in the original language in brackets, e.g. 'social pacification {soziale Befriedung}'.

## **Summary**

This study adopts a discursive approach that is most closely aligned with what Carabine (2001) termed a Genealogical Analysis and accordingly highlights the historical dimension of discourses. Furthermore, discourses are regarded as actively producing knowledges and 'truths', being enmeshed with power relations, and actively constructing social realities. The data consist of a range of texts that have been collected in archives, including parliamentary procedures and reports, media articles, letters to the editor, and articles published by non-governmental lobbying organisations. The

analytic process follows Seidel's (1998) model of noticing, collecting and thinking. Data were coded into a number of themes and subthemes and analysed in terms of how discourses around ADHD produce knowledges and 'truths', and how these have shifted across time. The analysis was informed by a dimensional approach that aimed to emphasise the visual, spatial and technical aspects of discourses, the rationalities they draw upon and produce, and the subjectivities they aim to cultivate. Moreover, the concepts of 'thought style' and 'thought collective' (Fleck, 1979) substantially informed the data analysis presented throughout the next three chapters.

Adopting a macro-perspective I argue that the methodological approach discussed throughout this chapter is particularly appropriate to answer the research questions. More specifically, the reliance on existing texts (i.e. naturalistic data), the elaboration of how subjectivities are being socially constructed, and the aim to challenge taken-for-granted assumptions are specific strengths in the approach chosen.

The next chapter presents the findings of the first theme identified in the visual data, i.e. how children are rendered knowable within relations of knowledge and power.

## 4 Rendering Children Knowable Within Relations of Knowledge and Power

*«It is characteristic of modernity that what it is to be human – and consequently what is to be a child – is a question which belongs to the domain of science»*

Karen Smith (2012, p. 34)

### Introduction

This first findings chapter is guided by the first specific research question i.e. 'how are children labelled with ADHD rendered knowable and governable?'. The chapter hence focuses on knowledges around the problematisation, identification and treatment of what has been called 'ADHD' in contemporary discourse. Such knowledges, presented as 'truths' (Foucault, 1977), reflect attempts of what could broadly be described as the human and social sciences to render humans knowable and governable. In terms of theory, above the general governmentality orientation of this thesis, this chapter particularly draws from Fleck (1979) and his concepts that are aimed at analysing scientific knowledge from a sociological point of view, which I have discussed in the Methodology (cf. **Thought Style and Thought Collective**, p.107).

My visual exploration of the media plane regarding how children are rendered knowable and governable in the discourse on childhood ADHD in Switzerland yields a certain emphasis on numbers, diagnosis and treatment practices. There is a particularly strong focus on psychotropic drugs as images of pills themselves, of children or adults holding pills or of children taking pills are

frequently depicted. Generally, one in ten images used in all collected media articles are depictions of drugs.

I argue that the construction of the 'ADHD child' takes place within certain knowledges that aim to render children governable, and within power/knowledge relations that limit what is sayable about ADHD. First, numeric knowledges, such as epidemiological rationalities and prevalence rates, aim to render the child knowable. Second, tools, such as brain scans and guidelines, aim to facilitate and standardise diagnostic processes. Third, treatment approaches are suggested based on 'scientific evidence'. These discursive practices, however, do not take place in a vacuum. Rather, they are significantly shaped by power/knowledge relations that privilege certain approaches and marginalise others through establishing discursive limits. Consequently this chapter is organised around these four themes i.e. numbers, diagnosis, treatment practices and signs of power/knowledge relations.

In terms of data, each section presents an image that I have identified as representative of the relevant theme. In a first round of text analysis I carefully read through all my data (i.e. texts from the media, the political and the parents' advocacy discourse planes) and coded texts that were relevant to each theme. A total number of 93 texts were coded to the theme Numbers, 67 to Diagnosis, 77 to Treatment and 73 to Signs of Power/Knowledge Relations. Based on these texts I then undertook an in-depth analysis in order to identify sub-themes. Within these sub-themes I coded aspects that were constitutive of that subtheme. For example, for the main theme Diagnosis I identified The German Guideline on ADHD as a sub-theme and Etiology and Genetics as one aspect (amongst others) of that sub-theme. Out of that analysis I then identified 26 text fragments as representative of these sub-themes. Most of these fragments referred to more than one aspect of the relevant sub-theme. In terms of discourse planes, nine fragments were from the media, one from the parents' advocacy and four from the political

plane. Additionally, three fragments were from the scientific plane, while nine were extracts from the *German Guideline on ADHD* (DGKJP et al., 2018a).

Let us now turn to the findings, beginning with the theme Numbers.

## Numbers

In this section I will elaborate upon the role of epidemiological knowledge in contemporary rationalities of government. Particularly, I will argue that the alleged prevalence rate of ADHD has become a self-fulfilling prophecy, legitimising mass drugging of children. The exploration will then turn its focus on how numbers are being used as diagnostic instruments.

### The Political Dimension of Numbers

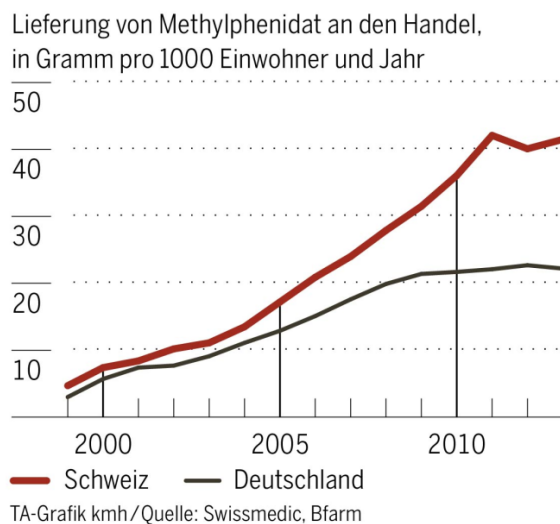


Figure 5: 'Supply of Methylphenidate to the market in Germany and Switzerland' (Straumann, 2015a)

When presenting the data numerical representations, such as graphs and charts, emerge frequently, particularly on the discourse plane of the media. The above graph, entitled 'supply of methylphenidate to the retail market, in grams per 1000 residents per year' (Straumann, 2015a) is representative of such material inscriptions (Latour, 1986) used throughout the discourse.

The article asserts that the supply to the retail market of methylphenidate in Switzerland is almost twice as high as in Germany. This is visually

emphasised by a bold, red line. While this point is clearly being made, the data behind it is somewhat obfuscated. For example, Swiss-based Swissmedic and German-based Bfarm use different formulae and data collection rationales to produce their statistics. Also, the amount of methylphenidate in 'grams per 1000 residents per year' does not seem to resonate with any units commonly used in everyday contexts. The numeric representation therefore aims to reduce complexity in order to produce a simple and strong message (Starr, 1987). What is obfuscated here, though, are the multifaceted factors that shape both prescription and consumption practices.

Such material inscriptions are not merely decoration. Numbers and their graphical representations have achieved a strong political power within modern technologies of government. As Nikolas Rose (2004) suggests, political numbers serve different objectives. They determine who holds power through election processes, operate as diagnostic instruments to assess public opinions, feelings and fears, and make government both possible and judgeable. Throughout the discourse on ADHD the significance of numbers as a tool to govern populations (Foucault, 1991a) is particularly apparent. As Best argues, statistics like the one depicted above have become 'an authoritative way to describe social problems' (2001, p. 13). They are seen as objective (Porter, 1996) and have gained widespread acceptance as suitable means of measuring social problems. Yet, activists promoting such 'problems', including ADHD, may also inspire opposition, which in turn may involve officials defending current practices and policies.

The emergence of ADHD on the political discourse plane as a site of contestation can be traced back to 11 June 2002, when a member of the Swiss Social Democratic Party filed an interpellation concerning the significant increase in prescriptions of Ritalin amongst schoolchildren (Brunner, 2002). The background was a report by the Swiss Federal Office for Public Health (2002, hereafter FOPH), concluding that the increase in prescriptions had been sevenfold between 1996 and 2000. Three questions

were included into the interpellation: whether the Swiss Federal Council (hereafter Council) (i) planned to monitor this phenomenon, (ii) planned to intervene in this field, and (iii) could specify whether the recognition of 'ADHD' as a disease was based on science. As justification for filing this enquiry the interpellant argued that 'many parents and teachers are concerned about this development' (Brunner, 2002). In its official response, the Council stated that

(i) The FOPH continues to support studies on the use of Ritalin. A study is being carried out on the epidemiological aspects of ADHD, the results of which should be available by the end of the year and published next year. The FOPH and Swissmedic, the Swiss Agency for Therapeutic Products, are also interested in articles from the specialised press and are working with international organisations such as the Council of Europe to gather relevant information on ADHD.

(ii) Between 1996 and 2000, the number of prescriptions for Ritalin increased sevenfold, which in fact represents a massive increase. However, this increase must be put into perspective as ADHD was not always treated in the past. Nevertheless, if prescriptions continue to increase at the same rate, a closer examination of the reasons for this and the necessity of the prescribed treatments would have to be carried out...

(iii) The diagnostic criteria for ADHD are clearly defined (DSM-IV psychiatric manual and WHO International Classification of Diseases ICD-10). These criteria are based on a scientific basis used by the medical profession, in particular by specialist doctors, including psychiatrists, child psychiatrists and paediatricians. These are complex criteria designed to distinguish ADHD from other behavioural disorders. (Swiss Federal Council, 2002)

In this statement the importance of numbers in the governance of and through ADHD becomes quite visible through reference to epidemiology, prescription rates and diagnostic criteria. These numeric knowledges are being employed here to render government both possible and judgeable (Rose, 2004). The following sections aim to elaborate on these.

## **Epidemiology and Prevalence Rates**

The above statement of the Council clearly reflects the occupation of contemporary rationalities of government with the models and logics of epidemiology (Dean, 2010; Wastell and White, 2017). Numbers serve here as a prediction regarding the prevalence of certain conditions. In the case of



ADHD that prevalence rate has been discursively defined to be five per cent. I have indicated in the literature review (see **Prevalence**, p.39) that epidemiological studies on ADHD have found prevalence rates to range from 1 to 17.8 per cent. Nevertheless, the idea of a fixed prevalence rate of five per cent has successfully been established in the discourse through constant re-iteration of this 'given truth' (Tait, 2006) on various discourse planes, including the political and the media planes. But what are being hidden here are the subjective methodological choices and statistical manipulations that underlie the determination of the prevalence rate. I will, however, consider such numeric manipulations in more depth later in this chapter.

As Jäger and Maier (2010) argue, it is not so much the individual text, graph, image or any other form of representation but the constant repetition of statements that form 'truths' in discourses. If numeric representations of 'truth', like a prevalence rate, are at stake, Best describes this process as 'number laundering' (2001, p. 35). Once established, that number becomes a norm against which all future actions should be measured. Arguably, in the case of ADHD, the idea of a given, fixed (worldwide) prevalence rate has taken on an 'aura of conviction' (Huff, 1954, p. 18). Through referring to it, those who 'know' (Foucault, 1991b) are endowed with credibility and authority. Referring to that 'truth' also serves to de-legitimise opposing views. Consider the following letter to the editor from a member of the board of the Swiss Society for Paediatrics in response to a critical interview published in the media:

[h]owever, about 5 per cent of children worldwide suffer from ADHD. This figure seems to be doubted by [the interviewee] and thus... stands *against the majority of experts*. I don't know of any studies that show that today more than the *expected 5 per cent* of affected children in Switzerland are treated with stimulants such as Ritalin. As a serious expert, one should not claim this without scientific evidence of abuse, and certainly not blame Switzerland for it! (Jenny, 2014, emphasis added)

The interview (Nowotny, 2014) itself did not touch on the concept of prevalence rate. Rather, it claimed that in most cases there are alternatives to the prescription of Ritalin in dealing with challenging behaviour in children.

However, mentioning the discursively agreed prevalence rate and presenting it as 'indisputable truth' (Best, 2001) enables the author of the letter to identify himself with the 'regime of truth' (Inda, 2005), particularly through reference to the fact that he is amongst the 'majority of experts'. The argument is then further strengthened by discrediting the interviewee. A 'serious expert', the author claims, would not challenge that prevalence rate and the prescribing practice that comes with it. In a similar vein, the Council de-legitimises opposing views in its considerations that led to the three official statements as mentioned above:

[w]hile treatment with Ritalin is questioned by certain circles who often lack knowledge of the medical aspects of ADHD, psychiatrists, child psychiatrists and paediatricians largely consider it to be the most appropriate therapy currently available (Swiss Federal Council, 2002)

Members of the counter-discourse are thus discredited because of their supposed lack of knowledge of the 'medical aspects of ADHD', while the inner circle of psychiatrists and paediatricians are declared those who 'know' (Foucault, 1991b). Such practices establish discursive limits, i.e. they limit what is sayable about a certain phenomenon at a certain point of time. I will elaborate on discursive limits in some more depth, though, later in this chapter.

The claim that five per cent of children worldwide suffer from ADHD reflects the 'thought style' (Fleck, 1979) of contemporary rationalities in the government (and medicalisation) of populations. This thought style claims that the underlying causes of ADHD are purely biological, and hence free from cultural, social and economic concerns (see, for example, Barkley, 2002). The reference to the prevalence rate of five per cent presents the claim as a 'given truth', and only prescription rates beyond this rate would consequently be regarded as 'evidence of abuse', because everything within this epidemiological prognosis would simply be 'expected'. Hence, it may be argued here that the prevalence rate becomes, to a certain extent, a self-fulfilling prophecy.

Arguably, this very prevalence rate has achieved a strong level of political power. One aspect of the intrinsic power of such numbers, Starr (1987) argues, is the ability to reduce complexity. The complexity of social, cultural and economical factors shaping the lives of children and, in turn, their behaviours, is therefore reduced to a single number. This number, then, presents the prevalence rate of what has been described as 'ADHD' as a neutral and objective 'truth', not only within Switzerland, or even Europe, but worldwide (Barkley, 2002). As Rose (2004) argues, such reductions of complexity are not neutral but are shaped by the ideologies and theories of those who perform them. The prevalence rate of five per cent thus carries an important political dimension and depicts the ultimate reduction of complexity (Starr, 1987). This number is then used by politicians, the media and the wider public alike to popularise the concept of 'ADHD'. Arguably, no other number has reached a comparable power in the discourse on childhood ADHD in Switzerland.

While admitting that there was indeed a significant increase in the prescription of Ritalin to children, the Council (2002, see quote above) legitimises this indirectly with epidemiological logic, by stating that 'ADHD was not always treated in the past'. This indicates that the prevalence rate has gained strong political power, legitimising medical intervention into the lives of an increasing number of children. While not referring explicitly to the prevalence rate, the Council states that there is only a need to further scrutinise the prescriptions if they 'continue to increase at the same rate'. If they, for example, were to increase at a lower rate, then there would potentially be no need for further concern. The implicit logic here again reflects epidemiological rationalities: the 'discovery' of ADHD led to a prognosis of how many children needed treatment. Consequently, a 'massive' increase in prescription rates was to be 'expected' and would only cause concern if it were to grow beyond a certain threshold. But if the growth rate in prescriptions were to slow down but still increase, then that would not be a cause for concern, as it would simply be reflecting state of the art of medical interventions. As Alonso et. al argue, however,

political judgements are implicit in the choice of what to measure, how to measure it, how often to measure it and how to present and interpret the results (1987, p. 3)

The political, therefore, reveals itself in the way numbers are collected and interpreted, since the underlying decisions are shaped by relations of power and knowledge (Foucault, 1991b).

Prescription rates, then, are always measured against the epidemiological prediction of a five per cent prevalence rate. More recent data about the use of methylphenidate (based on the amount sold) have shown that in Switzerland the overall consumption is almost twice as high as in Germany (Straumann, 2015a, see graph at the top of this chapter). The article that published this graph challenged the report released by the Council (2014), which concluded that the calculated 2.4 per cent of children taking this medication was in line with international guidelines that suggest that only half of the overall affected population of 5 per cent would be in need of medication. The numbers the Council report presented were calculated from the data of one of the bigger health insurers and then projected to represent the overall population of children in Switzerland. What they did not include, though, was the number of children treated under disability insurance {Invalidenversicherung}. Including them nearly doubles the prevalence rate of children taking ADHD medication and in turn raises the projected prevalence rate to 10 per cent. 'Apparently they have been forgotten or considered negligible', concludes the author of the article (ibid.). Yet, given that the 'expert report' of the Council had been produced within a field of political contestation and dispute, this conclusion might well have been missing 'the complex array of judgements and decisions' that underlie the work of the report (Rose, 2004, p. 208). However, the report was successful in terms of replacing the political dispute around prescription rates with a technical one, as the main concern of the debate shifted to the methodological assumptions and techniques underlying the generation and representation of data.

Furthermore, while a representative of the FOPH, on behalf of the Council, acknowledged the desirability of more accurate data, he argued that ‘the financial means are limited and there are more important issues’ and concluded that ‘there is no evidence that anything is not going well in the prescription of ADHD drugs in Switzerland’ (Straumann, 2015a). The discourse has thus been successful in moving the focus away from possible overmedication to technical and financial concerns, while again the prevalence rate has been called upon to legitimise current prescription practices.

After considering the political dimension of numbers and particularly the significance of the ‘truth’ of a given prevalence of ADHD, the next section will now elaborate upon how numbers may be used as a means of facilitating diagnostic processes, both on an individual and on a societal level.

## **Numbers as Diagnostic Instruments**

Numbers serve as diagnostic instruments on both the individual and the population levels. On the individual level they translate the lives of humans into numerical scales and percentages. In their statement (see above), the Council argued, with reference to both the DSM-V (APA, 1994) and the International Classification of Diseases ICD-10 (World Health Organisation, 1994), that ‘the diagnostic criteria for ADHD are clearly defined’ and ‘based on a scientific basis’. Moreover, the Council claimed that [t]hese are complex criteria designed to distinguish ADHD from other behavioural disorders (Swiss Federal Council, 2002). I will elaborate upon the ‘scientific basis’ of knowledges and ‘truths’ around ADHD in more depth in the sections on diagnosis and treatment later in this chapter and discuss here the claim to ‘complexity’ in these criteria, taking the DSM as an example.

The DSM aims to facilitate diagnostic processes through translating complex lived experiences into simplified numbers. According to this diagnostic handbook, then, there is a list of criteria that aims to diagnose the ‘mental disorder’ of ADHD. If a certain number of criteria are reached, then the

diagnosis of ADHD is to be given. The whole complexity of human life is thus broken down into a list of criteria, and a threshold that serves to distinguish abnormal behaviour from normal behaviour. The reference to 'normality' includes yet another numerical model. As I have discussed in the literature review (cf. **Developmentalism**, p.19), over the last two centuries developmentalism has focused on collecting numerical data on 'normal' development in humans. Together with contemporary developments in genetics and neuroscience, numbers serve as a powerful tool to diagnose and manage populations. As mentioned above, numbers therefore both render children governable and provide a rationale against which political power is being judged and legitimised.

Another concern with numbers as diagnostic tools is with the elaboration of public opinions, feelings and views. Techniques such as opinion polls seek to 'take the pulse of democracy' (Rose, 2004, p. 197). Within democracies such numerical scales and percentages promise to align political agendas with the values and beliefs of citizens. In 2015 the Konsumentenforum, a liberal consumerism agency in Switzerland, aimed to take the pulse of the wider public on different political themes by conducting a survey, called 'pulse meter' {Pulsmesser}. Participants were invited to rate their concern regarding 18 questions on a scale of 1 (no concern) to 6 (very high concern). According to the underlying rationale, a numerical value of 4 or higher was regarded as concern. The 18 questions themselves represented the main concerns that had been raised in the media over the previous twelve months (i.e. throughout 2014). The highest concern reported was the permanently increasing costs of the health system in Switzerland (4.6), followed by delinquency in youth (4.41), pollution of the environment as result of consumerism (4.37) and the prescription of pharmaceuticals such as Ritalin for children (4.28) (Meier, 2015). Numbers, here, aim to represent the concerns of the wider public. The complexity of data was 'filtered through layers of statistical manipulations' (Huff, 1954, p. 18) and then rendered into decimal-pointed averages. Presented in this precision, they claim a high level of accuracy. This obfuscates the necessary reductions in complexity

underlying their calculation, and thus their speciosity (Morgenstern, 1965). As Best (2001) argues, how best to measure or even to define public opinion has been subject to much debate and dispute. Often public surveys are flawed because of factors affecting the production of statistics, including poor definitions, flawed measurements and weak sampling.

Once a statistic has been created, it may then be further processed to produce graphical representations. I have mentioned earlier in this chapter that such material inscriptions (Latour, 1986) aim to render the world thinkable and governable. They 'diagnose' the feelings, views and concerns of the wider public and aim to align them with political agendas. In the case of the 'pulse meter', the survey included 1005 participants. The company that conducted the survey claimed that the survey was representative of the population of Switzerland. Indeed, the representativeness of a sample is much more important than its size (cf. Best, 2001). However, only few samples are truly random, and without having access to the sample it is rather difficult to determine whether the sample in question really reflected the population of Switzerland. The claim to its representativeness, though, is again based on the alleged objectivity of numbers (cf. Porter, 1996).

However, even if the question regarding representativeness remains unanswered, what is of interest here is that the statistic presented claimed that the wider society was concerned about the prescription of psychotropic drugs for children. This is particularly interesting as it potentially indicates that the hegemonic discourse, which is significantly shaped by key opinion leaders and substantially supported by the pharmaceutical industry (I will elaborate upon this later in this chapter under the heading Signs of Power/Knowledge Relations), does not necessarily reflect the views of the wider population. Rather, this again indicates how entanglements of power and knowledge significantly shape discourses. The concern with high prescription rates of psychotropic drugs for children appears to have arisen ever since the popularisation of ADHD and was first brought to parliamentary

attention in 2002 (see above). However, the contemporary hegemonic discourse seems to resist such concerns successfully.

## **Summary**

To conclude, this section has indicated the importance of numbers in the discourse around ADHD. In particular, I have pointed to the significance of numeric representations, such as statistical graphs, in presenting certain phenomena as ‘problems’. In addition, the findings indicate how claims to the epidemiological nature of ADHD aim to establish a given prevalence rate, against which all initiatives should be measured. I have argued that this rhetoric arguably turns the prevalence rate, to a certain extent, into a self-fulfilling prophecy. The section has concluded with elaborations upon how numbers may be used as diagnostic tools, both on an individual and on a societal level.

The next section aims to further elaborate on the knowledges around diagnostics in ADHD.

## **Diagnosis**

In this section I aim to point to the specific knowledges that legitimise the ‘diagnosing’ of an ever-growing population of children with ‘ADHD’. First, the elaboration draws attention to how pictorial representations of the brain aim to render ‘ADHD’ visible. Following this are elaborations around methodology, ‘evidence’ and ‘consensus’ regarding the production of guidelines that aim to standardise diagnostics and treatment of ADHD.

### **Rendering the ‘ADHD Brain’ Visible**

Let us first consider how pictorial representations of the brain aim to increase credibility of diagnostics in ADHD. Per definition, a diagnosis needs an underlying framework that categorises human experiences. The idea of ADHD as a ‘real’ disorder is consequently central, as it serves to legitimise both diagnostic and therapeutic practices. The question, however, of whether ADHD is real or not has been discussed now for two decades on multiple



discourse planes, including the political and the media planes. It continues to be highly controversial. On the media plane the discourse is increasingly shaped by the rise of neuroscience. For example, recent images depicting contemporary diagnostic practices show children wearing an electroencephalogram (EEG) sensor cap that is connected to a computer recording brain waves. The collected data are subsequently processed through complex algorithms and finally visualised. The following image shows such visual inscriptions:

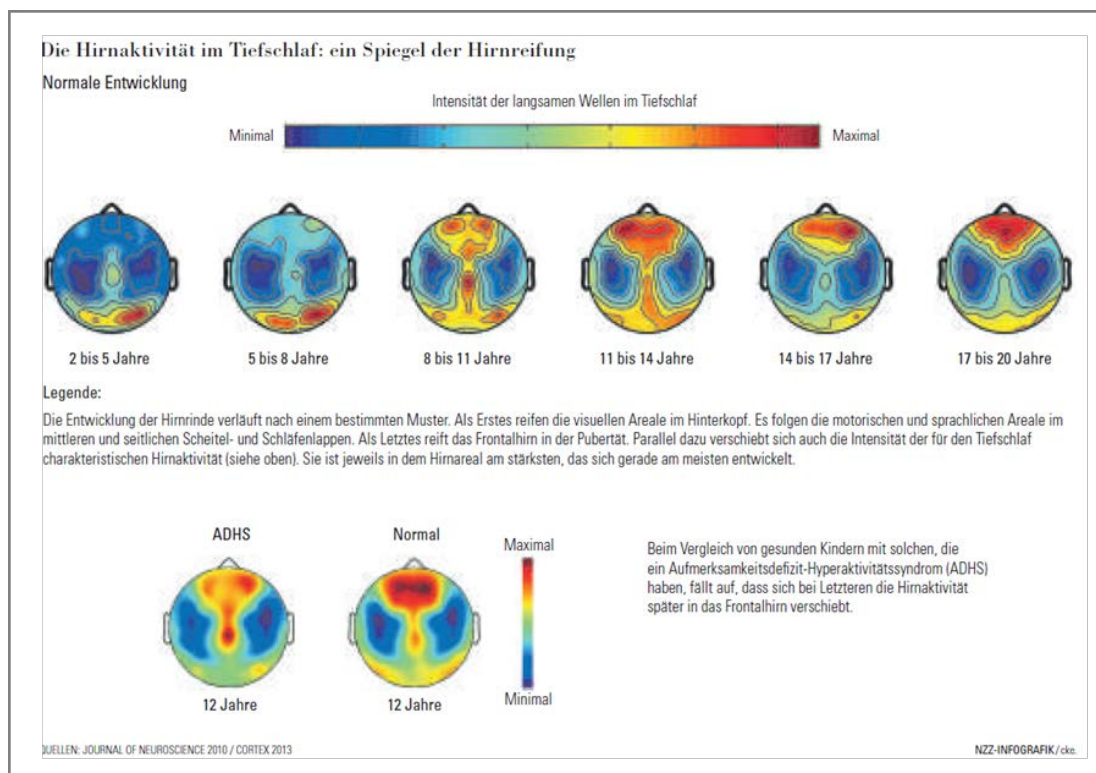


Figure 6: 'Visualised brain activities during deep sleep' (Stallmach, 2015)

The article around this image, entitled 'The brain matures during sleep', reports on research suggesting that the brain activities of 'healthy children' differ from those with ADHD during deep sleep (Stallmach, 2015). This is visualised through a colour scheme in which dark blue represents low activity and dark red high activity of slow waves. Through processes of inscription and representation this technology aims to render 'ADHD' visible, in support of the claim that this disorder is 'real'. These representations are, though, not neutral but theory-laden. For example, the underlying assumptions of brain

chemistry (and related imbalances) inform the way brain waves are measured, charted and interpreted against behaviour displayed in children (cf. Hasler, 2013). The underlying assumption here is that there is a consonance between what the data gathered say and how the child is (Place, 2000, p. 188). While such brain maps are certainly 'rhetorically powerful', they are basically not more than 'spatially distributed patterns of energy expenditure' and are hence very limited in their ability to support claims of brain dysfunctionality (Wastell and White, 2017, pp. 40–1). These limitations are also mentioned in the article, which concludes that 'causality remains unclear' (Stallmach, 2015). Nevertheless, the rhetorical power of the image above may still leave the impression on the reader that ADHD may actually be rendered visible through diagnostic processes.

I have indicated in the literature review (cf. **Critique on Medical Research**, p.53) that a major emphasis in mental health research generally, and ADHD research specifically, is on uncovering differences in the structures of brains. Neuroscience, therefore, is not only concerned with recording functional activity levels but also with measuring physiognomic differences in brains and deducing personality traits from these (see, for example, Kanai et al., 2011). An article recently published in the renowned publication *Nature* shows eight drawings of the brain in both lateral and medial perspectives and precisely maps a number of cognitive and metabolic processes in relation to their believed location within the brain (Faraone et al., 2015, p. 6). This is reminiscent of the theories brought forward almost two centuries ago by Franz Joseph Gall (1835) who proposed that human personality and behaviour are based on structural conditions of the brain.

It is against this background that Hasler describes this 'new physiognomics of the mind' as 'cyber phrenology' (Hasler, 2013, p. 26). He argues that the current preoccupation with imaging technologies is still based on the conceptual idea that the mind is divided into modules or mental organs in the brain. Hasler further highlights that ideas of cognitive functions, such as 'sustained attention' and 'pattern recognition', are not neutral but rely on

certain assumptions that are based on theoretical reasoning. One of the most popular ideas regarding children labelled with 'ADHD' is their supposed lack of control in their so called 'executive functions'. However, I will turn to these in the next chapter (see **Defining Good Behaviour**, p.187).

What is important to note here is that dominant imaging neuroscience depends on theory-laden assumptions, including the hypothesis that the mind is divided across the brain. Hasler concludes that the whole new fields that endow themselves with the prefix 'neuro' are based on rather vague assumptions and thus produce a 'neuromythology' rather than sound science. Nevertheless, images of brains are increasingly being used for political purposes for a wide range of themes, including to promote the medicalisation of 'ADHD' (see image above), to depict the effects of child neglect and abuse (Wastell and White, 2017) or to alert people to the addictive effects of pornography (Hasler, 2013).

From a governmentality perspective (Dean, 2010), what is of interest here is not so much the claims to 'truth' by the medical profession regarding differences in brain structure in children with ADHD, but rather the processes by which such claims to truth are being established. Biological 'reality', then, is constructed and endows medical practitioners with the ability to 'know'. Such constructed 'knowledge', then, is collected in professional guidelines to inform clinical practice. It is on such 'vademecum [sic] science' (Fleck, 1979, p. 112) that the exploration now concentrates.

## **The German Guideline on ADHD**

On 3 July 2018 a newspaper article announced that a new guideline regarding the treatment of children and adults with ADHD had been released in Germany and that it was likely to be adopted in German speaking Switzerland (Hehli, 2018). I have mentioned in the literature review (cf. **Inference**, p.25) that reaching conclusions on the basis of evidence and reasoning, termed inference, designates a core domain of professional practice. An important means of helping professionals facilitating the

inference process are guidelines that are issued for what is claimed to be a specific disease entity, such as 'ADHD'.

One of the key points the article presents is that the use of the 'controversial drug Ritalin' should also be considered in cases of medium severity. Previously, behavioural therapy was considered the first choice for both mild and moderate cases of ADHD (Hehli, 2018). Arguably, such a shift in the use of pharmaceuticals might significantly increase prescription rates, and it might therefore be worth it to elaborate upon the underlying rationale that legitimated this shift. An important part of the legitimacy is being built around the argument that the guideline is based on 'science'. One of the experts interviewed, a child psychiatrist and director of a clinic for child and adolescent psychiatry and psychotherapy in Zurich, argued 'that for the first time, a German-language guideline which is scientifically based is now available' (ibid). The German guideline *Attention Deficit / Hyperactivity Disorder (ADHD) in Childhood, Adolescence and Adulthood* (DGKJP et al., 2018a, hereafter *Guideline*) is presented as being both evidence- and consensus-based and consequently reached the highest level of classification (S3) according to the German Working Group of the Scientific Medical Societies (AWMF). The classification S3 requires authors to comply with the following requirements: the body of involved experts must be representative in the relevant field; the review, selection and evaluation of literature must be systematic; and the process of building consensus must be structured (Muche-Borowski and Kopp, 2011).

Let us have a closer look at the *Guideline*, which is structured around three chapters: introduction, recommendations and appendices. In the introduction the 'disease entity' {Krankheitsbegriff} of 'ADHD' is discussed and introduced with reference to its elements, including aetiology, genetics, neuropsychology and diagnostics. The introductory chapter concludes with the identification of gaps and recommendations for future research. The core of the *Guideline*, the recommendations, is organised around the following themes: (i) diagnostics; (ii) intervention-algorithm; (iii) psychological-psychotherapeutic

interventions; (iv) pharmacological interventions; (v) inpatient support, child protection and rehabilitation services; (vi) transition; and (vii) self-help.

### **Aetiology and Genetics**

Let us first consider the general elaborations regarding the disease entity of 'ADHD' that the *Guideline* offers. As claimed in the hegemonic discourse, ADHD is considered a valid mental health disorder with a highly genetic background. Given that the *Guideline* is a 198 page long document, however, the part on aetiology is rather limited:

[t]he conditions of development are heterogeneous and have not yet been fully clarified. It is clear that multiple interacting factors are involved in the etiology of ADHD. Genetic predispositions and pre-, peri- and early postnatal environmental influences, which influence structural and functional brain development, play a decisive role (DGKJP et al., 2018a, p. 13)

That the conditions of development of ADHD 'have not yet been fully clarified' is a rather positive way to describe that in spite of 'the truly industrial scale of the research, no consistent route from gene to disorder has been found' yet (Wastell and White, 2017, p. 78). After this rather short elaboration on aetiology, roughly one page is dedicated to genetics. The section starts with the claim that '[f]amily studies show that ADHD occurs more frequently in families', and that '[a]doption and twin studies have shown that family accumulation is largely due to genetic factors' (DGKJP et al., 2018a, p. 13). It is further argued that, based on these studies, genetic heritability has been found to be 76 per cent. Let us briefly consider the only study mentioned to back this rather strong claim, entitled 'Molecular genetics of attention-deficit/hyperactivity disorder' (Faraone et al., 2005).

Faraone et al. admit that 'in the absence of molecular genetic data, family studies cannot disentangle genetic from environmental sources' (2005, p. 1313). Thus, research in behavioural genetics has tended to turn to twin studies to 'determine whether genes account for the familial transmission of a disorder' (ibid.). However, twin studies have significant methodological flaws, as has been problematised in the literature review (see **Causes**, p.38). After repeating the assumptions derived from behavioural genetic research, the

authors of the paper then turn to molecular genetics. The findings discussed appear to be highly contradictory. For example, in the 'Dopamine 4 Receptor', some studies have found a 'small but statistically significant' association between ADHD and the 7-repeat allele, while 'recent studies have been unable to document significant associations' (ibid.). Small effect sizes and conflicting results do not necessarily suggest a high heritability of ADHD but the authors conclude that

[a]lthough twin studies demonstrate that ADHD is a highly heritable condition, molecular genetic studies suggest that the genetic architecture of ADHD is complex. The handful of genome-wide scans that have been conducted thus far show divergent findings and are, therefore, not conclusive (Faraone et al., 2005, p. 1319)

The claim that twin studies 'demonstrate that ADHD is a highly heritable condition' clearly reflects the thought style at work here. Although the authors mention that 'genome-wide scans' are 'not conclusive', their main argument is built around flawed twin studies to keep it within the 'scientific fact' that has been discursively agreed upon. When new research in molecular genetics potentially undermines that scientific fact, then the findings are either ignored or re-interpreted in a way that fits with the thought style. In this case, the small effects are re-interpreted as being 'consistent with the idea that the genetic vulnerability to ADHD is mediated by many genes of small effect' (ibid.). Members of a certain thought collective are expected to comply with the current thought style and hence confirm rather than challenge earlier findings. Challenging them would exclude them from the circle of 'general experts', and put them into an isolated position in the circle of 'special experts'. Faraone et al. therefore suggest that

[t]hese small and sometimes inconsistent effects emphasize the need for future candidate gene studies to implement strategies that will provide enough statistical power to detect such small effects (2005, p. 19)

Again, the thought style here is very visible. Rather than problematising that decidedly contradictory findings with small effects sizes may question the idea of a high heritability of ADHD, the authors suggest that more research with 'enough statistical power' would be needed to confirm what has already

discursively been defined as ‘truth’ (Foucault, 1991b). Although these contradictory findings are briefly mentioned in the *Guideline*, the authors conclude that

[i]n summary, the genetic study results support the theory that ADHD is an expression of a genetically (co-)induced neuronal developmental disorder (DGKJP et al., 2018a, p. 14)

By putting the ‘co-’ in brackets, the focus is clearly been put on ADHD being a genetically induced disorder. While in the journal article the authors admitted that their findings are ‘not conclusive’ (see quote further up, Faraone et al., 2005, p. 19), the impersonal nature of what Fleck (1979, p. 112) calls ‘vademecum [sic] science’ allows for a much more positive conclusion regarding the heritability of ADHD. This is then further translated into popular science. For example, in one collection of articles published by Elpos, a paediatrician holds that ‘ADHD in its disposition is always inherited’ and claims that this ‘has been scientifically proven in recent years’ (Simchen, 2016, p. 11). While these considerations of both aetiology and genetics in the *Guideline* seem to be rather vague and limited, they nevertheless form the basis for the recommendations regarding diagnosis and therapy. It may thus be worthwhile to have a closer look at the recommendations and the specific evidence they are based on. It is to this evidence base that the examination now turns.

### **The Evidence Base of Recommendations**

The rationale, process and considerations regarding the assessment of evidence are recorded in a separate document titled *Guideline Report of the Guideline «Attention Deficit / Hyperactivity Disorder (ADHD) in Childhood, Adolescence and Adulthood»* (DGKJP et al., 2018b, hereafter *Guideline Report*). To outline the scope and purpose of the *Guideline*, the *Guideline Report* starts with the following sentence:

[a]ttention deficit hyperactivity disorder (ADHD) is one of the most common mental disorders with a prevalence of about 5% in childhood and adolescence (DGKJP et al., 2018b, p. 9)

Again, the self-fulfilling prophecy of the claimed prevalence rate (see section on numbers above) is being used here to justify actions of the 'regime of truth' (Foucault, 1977). Given the significant political power the prevalence rate of ADHD holds, it may be useful to consider the evidence the *Guideline* draws upon to substantiate it. The evidence the *Guideline* refers to consists of an article published in *Nature* (Faraone et al., 2015) and two meta-analyses (Polanczyk et al., 2007, 2014). There is, though, a certain circularity here, since the article published in *Nature* refers to the 2007 meta-analysis as the only reference to back the claim of a fixed prevalence rate of five per cent. Furthermore, the chair of the *Guideline* is also a co-author of both the *Nature* article and the 2007 meta-analysis. Arguably, the influence of 'key opinion leaders' is very visible here and their extensive links to the pharmaceutical industry are well documented in these three articles. I will, however, elaborate upon the role of key opinion leaders later in this chapter. Let us first consider the meta-analyses in some more depth.

Drawing on complex statistical manipulations, such analyses are often an integral part of systematic reviews (Baker et al., 2009). To address methodological, clinical and statistical heterogeneity across the studies they review, meta-regression, combining meta-analytic techniques with linear regression principles, is employed. In the case of ADHD prevalence in children, this complex manipulation of weighted data led to a worldwide prevalence rate of childhood ADHD of 5.29 per cent (Polanczyk et al., 2007). The final multivariate meta-regression model by Polanczyk et al. identified (i) the requirement of 'impairment' for the diagnosis, (ii) diagnostic criteria, and (iii) the source of information as significantly associated with the prevalence rates. All these variables point to substantial differences in the understanding and application of the diagnosis of 'ADHD', such as between the diagnostic criteria as defined by the World Health Organisation (1994) versus those of the American Psychiatric Association (APA, 1994), and between different versions of these diagnostic handbooks.



Moreover, diagnostic processes are significantly biased on parental and teacher reporting, and the understanding of what constitutes an impairment and whether this is a required criterion to diagnose ADHD. However, since the setting of a medical practice room is quite far from that of a classroom, doctors tend to mainly rely exactly on teacher and parental reporting. In addition, the geographical locations of the studies affected the prevalence rate, which presumably indicates differences in the understanding of 'deviant behaviour' across cultures. Isolating these variables may well lead to a simplified picture of a consistent prevalence rate of 5.29 per cent. But even the authors themselves suggest that their 'results should be interpreted with caution because of the large variability found in all analyses' (Polanczyk et al., 2007, p. 946).

Furthermore, meta-regression should be generally considered hypothesis-generating only due to its reliance on aggregated data (as opposed to patient-level data) and its observational nature. Hence, even if we could think of an idealised, laboratory-like world in which significant members of the diagnostic processes (such as doctors, psychologists, teachers and parents) shared a common understanding of which diagnostic criteria to use and how to consistently interpret behaviour displayed in children against these, what relevance would that have to the countless realities experienced by children around the world?

While clearly a sophisticated statistical manipulation of data, meta-regression cannot determine causality (Baker et al., 2009). Rather, in this particular case, it establishes a number that does isolate cultural and geographical variance to produce a hypothetical number. Given that this number is based on DSM-IV (APA, 1994) criteria, an increase of the prevalence rate would be expected in the wake of the adoption of DSM-5 (APA, 2013). While the follow-up meta-regression analysis (Polanczyk et al., 2014) indicates that prevalence rates significantly increased with each new issue of the DSM, it does not yet account for DSM-5 criteria. This is presumably because of a lack of relevant research, since DSM-5 was only released in 2013, i.e. one

year before the meta-regression analysis was published. Ignoring these complexities, the prevalence rate of ‘about 5% in childhood and adolescence’ (DGKJP et al., 2018b, p. 9) serves primarily as a means of political activism to legitimise the mass drugging of children.

### **The Utopian Character**

After the reference to the ‘given truth’ of the prevalence rate, the authors of the *Guideline* then argue that children with ADHD face problems at school as well as in their social interactions with family members and friends. However, the main concern seems to be with the future citizen:

[L]ongitudinal studies have shown that adults affected by ADHD have lower educational attainment, lower income and socioeconomic status, increased risk behaviour, more frequent involvement in road accidents and more frequent breaking of the law (DGKJP et al., 2018b, p. 9)

The ‘utopian character’ (Dean, 2010) of the *Guideline* reveals itself in the endeavour to address these issues. Therefore, the *Guideline* aims to reduce misdiagnosis, school dropouts, delinquency, road accidents, substance abuse, suicide attempts and suicides, and early mortality (DGKJP et al., 2018b). Moreover, it seeks to increase the average level of socio-economic status and the average level of educational degree achieved. The *Guideline*, thus, assumes that we can draw upon a certain body of knowledge to reform human beings and govern them towards desired ends. In so doing it emphasises the aim to ‘provide empirically founded recommendations for action’ (ibid., p.10). Let us consider the evidence these recommendations are based upon. In total the *Guideline* encompasses 84 recommendations and rates the ‘quality of evidence’ they are based upon.

The *Guideline Report* highlights the ‘methodological accuracy’ during the process of the development of the *Guideline* through following the ‘guidance manual and rules’ (ibid., p.16). The very starting point for drafting the *Guideline*, though, was not a literature review of recent research. Rather, the authors decided to search for existing guidelines. A total of nine such guidelines were identified, all published between 2006 and 2011. They were

then assessed for their accuracy and quality based on the German Tool for Methodological Guideline Evaluation (AWMF and ÄZQ, 2008). Based on that evaluation the clinical guide *Management of Attention Deficit and Hyperkinetic Disorders in Children and Young People* of the Scottish Intercollegiate Guidelines Network (SIGN, 2009) was selected as the source guideline, and four other guidelines were included in the development of the *Guideline* as reference sources. The evidence presented in these documents, therefore, was used as a basis, and only for the time frame of 31 October 2014 to September 2016 was a dedicated literature review performed.

Vade mecum science (Fleck, 1979), rather than journal science, is thus used here as the basis for the development of what is being regarded as the highest standard of an ‘empirically based’ guideline. Each recommendation is then rated in their ‘quality of evidence’ as either high, moderate or weak according to the classification system GRADE as described in AWMF (2012). Hence, only 4 recommendations are based on high quality of evidence, while 15 are based on moderate quality and 8 on weak. 68% of the recommendations (57 out of 82), however, are based on consensus and called ‘good clinical practice’, reflecting

the clinical experience of the members of the guideline group as a standard of treatment where *no experimental scientific research is possible or intended* (DGKJP et al., 2018b, p. 29, my emphasis)

In other words, the *Guideline* claims that its recommendations are based on ‘evidence’ but they are predominantly based on consensus without reference to research, because this was not possible or not intended. There is, though, no reference to why scientific research was not possible in the majority of recommendations. Consensus on ‘good clinical practice’ was reached when at least 75 per cent of the involved ‘experts’ opted for the recommendation. In two cases a ‘majority agreement’ was reported rather than a consensus, indicating a range of  $> 50 \leq 75$  per cent of agreement. Hence the *Guideline* primarily reflects clinical practice rather than scientific knowledge. The high

ranking (S3) therefore seems to be concerned much more with systematic and structured processes than with the quality of the scientific evidence they draw upon.

This reflects the requirements for reaching the classification 'S3' articulated by Muche-Borowski and Kopp (2011), as mentioned above, and, more generally, the aim of specialists to mechanise and objectify their expertise (Porter, 1996). While the methodological assumptions and decisions, as well as the processes that led to the consensuses, are well documented and follow defined criteria, the quality of the evidence and hence the claim to the 'scientific base' of the *Guideline* seems to be rather questionable. Arguably, the *Guideline* is based much more on consensus than on evidence, which indicates the power of professions to define their professional practice.

Yet, this power is not without contestation. As Hanses (2007) argues, the tendency to develop extensive guidelines also reflects the influence of another discourse. Advanced liberal ideas of 'efficiency' and 'outcome-based interventions' ask for evidence-based problem analysis and professional directives through guidelines, standardised training programmes and intervention strategies. While such guidelines enable professionals to describe and compare children, they also increasingly subject these professionals to organisational knowledges in their clinical practice. Hanses suggests that strategies of evidence-based medicine demount the competence of professions to inference and turn them into implementing bodies of guidelines (ibid.). In addition, the individual experiences of children affected by these practices seem to be of little interest here. The complex interactions of those considered for an 'ADHD' diagnosis with their life-worlds (cf. Thiersch, 2008) are reduced to simple categorisations, and their 'needs' both created and addressed through a highly technical and supposedly scientific and objective treatment approach.

## Summary

This section has focused on the knowledges and ‘truths’ around diagnosing ADHD. I have argued that visual representations of the brain are not neutral but theory-laden. Nevertheless, this imagery is being used to substantiate the claim that ADHD is a valid, brain-based disorder. The discussion then went on to elaborate upon the *German Guideline on ADHD*, with particular focus on the evidence provided to substantiate its recommendations. I have argued that the aetiological basis of ADHD is very vague, while the claims to its genetic basis are based on vade mecum science rather than journal science. The section has concluded by indicating that the *Guideline* reflects the freedom of professionals to define their professional practice rather than scientific knowledge. Against these considerations, the utopian character of the *Guideline*, such as the aim to increase the average level of socio-economic status and the average level of educational degree achieved in those targeted, seems to be problematic. But it is this utopian character that aims to legitimise the recommendations regarding the treatment of ADHD. It is to these suggested treatment interventions that the discussion now attends.

## Treatment

As I have argued in the literature review (see **The Shift from Psychoanalysis to Pharmacology**, p.35), psychotropic drugs have increasingly been promoted as the standard treatment for ADHD. Against this backdrop this section briefly elaborates upon the promotion of psychotropic drugs and then goes on to examine the evidence underlying the recommendations in the *Guideline* regarding the prescription of drugs.

## Promoting Psychotropic Drugs



Figure 7: 'For years Jan had to take Ritalin. In the meantime, he was able to stop taking the medication' (Schirm-Gasser, 2015a)

The picture above shows a boy holding a pill. Jan, as the boy is called for the purposes of the article the picture was published with, was forced to take Ritalin from the time he entered primary education. His teacher told his parents that if he did not start taking psychotropic drugs to alter his behaviour, he would be expelled from school. The importance of social space to prescription practices will, however, be discussed in the next chapter. The picture is a rather strong representation of the current hegemonic discourse on ADHD that suggests ignoring the lived experiences of children whose behaviour has been problematised, and reducing interventions to the potentially favourable effects that a pill might bring. As Zola (1977) argues, once 'ADHD' has been accepted as an 'illness' it becomes something that can and should be eliminated, be it with drugs or other medicalised interventions. The picture places the pill in the centre, while the boy in the background is blurred. This powerfully reflects the effects of the professional discourse around ADHD on children. Once the apparently neutral diagnostic

process along the *Guideline* (see above) has been performed and the label 'ADHD' assigned, the issue is not whether the undesirable behaviour is being dealt with but when. The issue of what freedom an individual should have over his or her body is shunted aside through the de-politicising effects of the labels of 'illness' and 'health' (ibid.). As Zola further argues, the patient has little right of appeal to the label since they do not know what is best for them. It is in this context that the article problematises that '[f]or years Jan had to take Ritalin' (Schirm-Gasser, 2015a).

However, these 'regimes of truth' (Foucault, 1977), while representing the current thought style, are not without contestation. Arguably the two most controversial issues in the discourse around ADHD are whether it is a distinct and concise 'disease entity' at all and whether the mass drugging of children is justified. As discussed above, the aetiological basis of ADHD is rather vague and the claim that it is primarily genetically inherited remains a hypothesis that is increasingly being challenged through more recent epigenetic research. To consider whether the mass drugging of children is justified against such a weak aetiological position, the next section examines the evidence that supports the prescription of stimulants for children in the *Guideline*.

## **Evidence Regarding Pharmacological Interventions**

The question of whether non-pharmacological, pharmacological or both interventions should be used in the treatment of a child labelled ADHD is dealt with in the *Guideline* under the heading 'interventions-algorithm' (DGKJP et al., 2018a, p. 44). Recommendation 1.2.2 suggests framing all interventions under the concept of a multi-modal therapy, which may include psychosocial, pharmacological and complementary elements. Also, it is recommended to use 'psycho-education' as a means of informing the child and his or her relevant caregivers about ADHD, to develop an individual disorder-concept {Störungskonzept}, and to introduce treatment options. This aims to enable the child and his or her parents to give their informed consent to the treatment plan. The recommendation further argues that

pharmacological treatments should not start before the age of three (this used to be six in the previous version of the *Guideline*). For ADHD of low severity, non-pharmacological interventions are suggested but pharmacological ones may be considered in some cases. For ADHD with medium severity, non-pharmacological, pharmacological or both intervention options may be considered (this used to be primarily non-pharmacological in the previous version of the *Guideline*). As mentioned above, this is the main point of critique regarding the new *Guideline*, as it arguably may lead to an increase in the use of psychotropic drugs in children. For ADHD with high severity, pharmacological interventions are always recommended, while further intervention options may be considered.

The rationale here, thus, seems to be to intervene earlier, i.e. in younger children, and more comprehensively, i.e. in cases of less severity. The 'quality of evidence' for this particular recommendation, though, is again based on agreement, with a reported consensus of 76.9 per cent. Given the minimum of 75 per cent of consent to reach consensus, this was only just achieved, which may reflect the high level of controversy around this issue. The concerns with pharmacological treatments are then being dealt with under a separate grouping. In total, 41 per cent of all recommendations of the *Guideline* concern pharmacological interventions (35 out of 84). Out of these, 31 are based on consensus rather than on evidence. Hence only four recommendations regarding pharmacological interventions are based on 'scientific evidence', of which two are rated high and one each is rated moderate and weak. The following diagrams visualise the significant proportion of expert consensus that substantiated the recommendations:



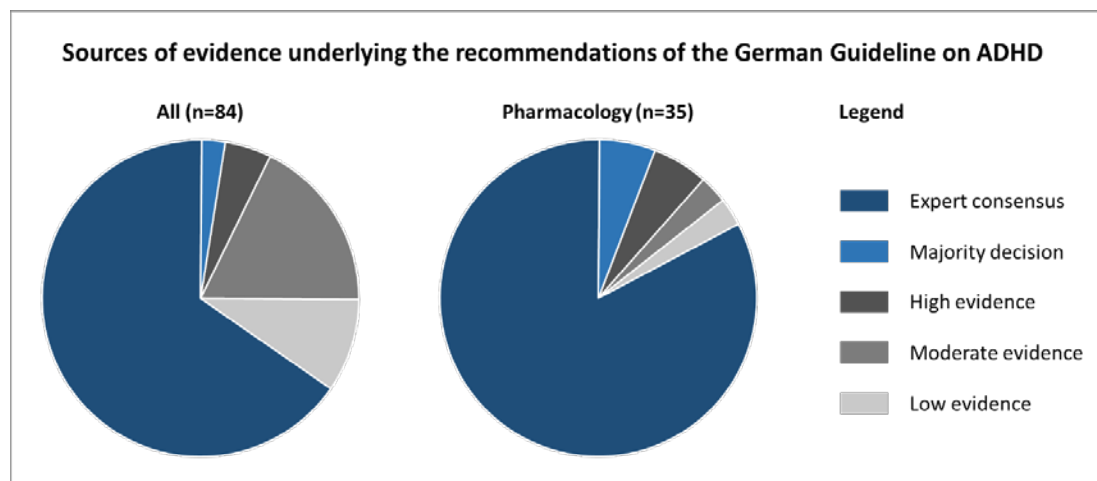


Figure 8: Proportional visualisation of the sources of evidence underlying the recommendations of the German Guideline on ADHD (DGKJP et al., 2018b)

These pie charts impressively visualise that the recommendations of the *Guideline* in general, and particularly regarding pharmacology, are basically clinical preferences (represented here by ‘expert consensus’ in dark blue and ‘majority decision’ in light blue) of doctors, rather than intervention strategies based on scientific evidence.

Let us now consider one of the two recommendations whose evidence base has been rated as being of high quality in some more depth. Recommendation 1.4.2 is concerned with the type of drugs suggested for treatment:

#### 1.4.2 Which formulated products {Präparate} are recommended for treatment?

If drug treatment is indicated, stimulants (methylphenidate, amphetamine and lisdexamphetamine), atomoxetine and guanfacine should be considered as possible options for the treatment of ADHD. The current approval status should be taken into account (DGKJP et al., 2018a, p. 69)

The shift towards earlier and more comprehensive drug treatment (see above) and the preference for stimulants again reflect the hegemonic thought style. Let us therefore consider the evidence base this recommendation is based upon. The authors of the *Guideline* admit that

the exact mechanisms of action of the stimulants are not yet known and may differ in different brain regions as well as between children and adolescents (DGKJP et al., 2018a, p. 111)

While this sounds rather vague, the authors of the *Guideline* are nevertheless quite positive about the quality of evidence recommendation 1.4.2 is based upon. They do not back their claim with reference to research, however. Rather, they refer to the high ratings that stimulants have been assigned to by the authors of the source and reference guidelines (as mentioned above, these are AAP, 2011; NICE, 2009; SIGN, 2009). Again, the assessment of the quality of evidence is based on vade mecum science rather than journal science. But these claims to efficiency of pharmaceuticals within this body of vade mecum science are in stark contrast to the conclusion of the systematic review of journal science (Storebø et al., 2015) published by the Cochrane Foundation, 'a global, independent network of researchers, professionals, patients, carers, and people interested in health' (Cochrane, n.d.).

The reference to independence here has to be interpreted against the significant role the pharmaceutical industry plays in controlling research agendas and employing the influential marketing strategies that I have discussed in the literature review (see **Pharmaceutical Industry**, p.44). Only one of the 18 authors of the systematic review declared a conflict of interest in terms of links to the pharmaceutical industry. To compare, 28 out of 39 (72 per cent) of the authors of the *Guideline* have reported a conflict of interest.

In their systematic review Storebø et al. concluded that

[f]indings suggest that methylphenidate might improve some of the core symptoms of ADHD - reducing hyperactivity and impulsivity and helping children to concentrate. Methylphenidate might also help to improve the general behaviour and quality of life of children with ADHD. However, we cannot be confident that the results accurately reflect the size of the benefit of methylphenidate (Storebø et al., 2015, p. 3)

However, the authors stressed that 'the *quality of the evidence was very low* for all outcomes', and that they consequently 'cannot say for sure whether taking methylphenidate will improve the lives of children and adolescents with

ADHD' (ibid., p.3, my emphasis). While the authors of the *Guideline* acknowledge the findings of the Cochrane systematic review, they argue that Storebø et al. were not following the Cochrane guidelines stringently but introduced a further domain, 'conflict of interest', to assess the risk of bias. Without discussing the findings in detail, the authors conclude that

[o]verall, the bias risk assessment is inappropriate, and the conclusion is therefore inadequate in terms of assessing the evidence of efficacy of MPH [Methylphenidate] in the treatment of children and adolescents with ADHD (DGKJP et al., 2018a, p. 113)

This again reflects the strong influence of the thought style at work here. The idea that pharmacological interventions are paramount to any other treatment, and that this is being backed by evidence of high quality, has become 'thought constraint' (Fleck, 1979, p. 123). Since that constraint determines what can be legitimately claimed, opposing views are being marginalised through a range of practices. In this case, the authors of the *Guideline* chose to discredit the Cochrane systematic review. Furthermore, they chose to substantiate their argument by highlighting research that supports the thought style at work, while simultaneously ignoring research that opposes it.

In particular, they refer to the findings of the Multi Treatment Approach Study (MTA Cooperative Group, 1999) to claim that stimulant treatment is superior to any other form of treatment. Yet, they also admit that data on long-term benefits of stimulant therapy are limited. They conclude that both the SIGN guideline (2009) and the 24 month follow up MTA study indicate a positive effect over a term of two years. What they omit here, though, are the findings of both the 3 year (Jensen et al., 2007) and 8 year (Molina et al., 2009) MTA follow up studies. As I have argued in the literature review (see **Core Messages in the ADHD Debate**, p.49), the initial MTA study (with a duration of 14 months) found that stimulants were superior to any other treatment, which arguably led to a discursive event (Jäger and Maier, 2010), considerably shaping the discourse on ADHD towards the preference of stimulant use as the first choice regarding treatment approaches. Since the

follow up studies contradict these findings and thus the thought style, they are consequently ignored by the authors of the *Guideline*. Hence it may be argued that the evidence supporting the treatment of children with stimulants seems to be rather limited. The preference for medication may therefore reflect clinical preference rather than being an intervention based on sound research.

Although claiming to be evidence based, what the *Guideline* primarily seems to achieve is a better representation of contemporary clinical preference and practice. As a Swiss child psychiatrist who was involved in the development of the *Guideline* as a peer-reviewer argues, the individual level of challenge of coping with every-day life {Alltagsbewältigung} in children, rather than the severity of symptoms, was justifying treatment with stimulants (Hehli, 2018). The idea here is that ADHD leads to distress in children, since they are limited in their ability to cope with 'every-day life'. It is against this idea that the mass drugging of children is being justified. I will elaborate upon the importance of distress in the discourse around ADHD in the next chapter (see **Representations of Distress**, p.175). The child psychiatrist cited above concludes that in the light of the discussion around reducing challenges in coping with every-day life, 'the new German guideline rather better reflects the *already common practice today*' (Hehli, 2018, emphasis added).

## Summary

This section has elaborated upon the knowledges and 'truths' around the treatment of ADHD in children. I have argued that the visual imagery that is employed throughout the discourse reflects the professional practice that tends to ignore the complex lived experiences of children and to reduce their needs to pharmaceutical treatment. I have further argued that the rationale in the light of the new *German Guideline on ADHD* seems to be to intervene earlier, i.e. in younger children, and more comprehensively, i.e. in cases of less severity. The exploration then went on to scrutinise the evidence basis the treatment recommendations of the *Guideline* are based upon. I have argued that most recommendations are not based on evidence, and if they

are, the evidence is significantly biased through selection and omission. This reflects the relations of power and knowledge that enable the 'regime of truth' to significantly shape the hegemonic discourse, and consequently to define what counts as 'truth'. It is these relations of power and knowledge the examination now concentrates on.

## **Signs of Power/Knowledge Relations**

This section elaborates upon how knowledges that have been discussed throughout this chapter, and that are presented as 'truths', are entangled with systems of power. As I have mentioned in the methodology chapter (see **Discourse, Power and Knowledge**, p.79), Foucault suggests a circular relationship between 'truths', i.e. systems of ordered procedures and 'regimes' that produce and sustain these systems. It is this 'regime of truth' around ADHD the elaboration now turns to.

In particular, I will elaborate upon power relations around the privilege to prescribe and, more generally, within the wider network of actors around the popularisation of ADHD. Moreover, I will indicate how claims to neutrality and objectivity aim to endow members of the hegemonic discourse with authority, and how these seek to establish and maintain the boundaries of what can legitimately be said about ADHD.

## The Privilege to Prescribe



Figure 9: "Ritalin: General practitioners are not critical enough of the 'miracle drug'" (Habicht, 2009a)

The image above has been published in an article titled 'Ritalin boom: Heavy accusations against Swiss general practitioners'. It is representative of the images in the discourse on the media plane that represent members of the 'psy complex', and in particular medical doctors, as those who 'know' in the context of ADHD. Such imagery contributes to the maintenance of the claim that ADHD is a medical problem.

This particular image shows a rather typical practice room of a medical doctor. A number of tools in the room that aim to render the body more visible are always at the doctor's disposal. For example, assessing height, weight, pulse rate and blood rate aims to 'sort' and 'externalise' the body (see Place, 2000). Additionally, the image on the wall in the background aims to render the body knowable by illustrating elementary components of human anatomy. Such 'inscription devices' (Latour and Woolgar, 1986) aim to transform a material substance into a diagram or figure. Apart from these tools and figures the room is rather barely furnished. As I have suggested earlier in this chapter, this setting is quite different from a typical school

setting (in which children labelled with 'ADHD' usually are rendered problematic), and general practitioners thus tend to rate the behaviour of children based on reports from parents and teachers rather than on their own observations.

The article that published the image above problematised that general practitioners were not critical enough regarding the prescription of Methylphenidate, considering it as a 'miracle drug'. However, as I have mentioned in the literature review (cf. **Professionalism**, p.23), the power of the medical profession rests essentially on the privilege to prescribe. In the particular case of 'ADHD', this includes the right to subject children to pharmaceutical treatment in order to amend their behaviour. As with many other 'behavioural disorders' (see APA, 2013), it is medical doctors who claim the monopoly over the definition of deviance and the remedies needed to address it (Illich, 1977). In his report regarding the potential abuse of psychotropic drugs, including Methylphenidate, for the purpose of human enhancement, the Council emphasises the authority of medical doctors:

[u]nder current law, the FOPH [i.e. the Federal Office for Public Health] and Swissmedic are not authorised to impose restrictions on prescribing doctors. They may only issue recommendations, in particular in the form of information letters to the medical profession. The information letter on Ritalin approved by Swissmedic underlines the need for holistic treatment of ADHD. In addition to medication, this should also include psychotherapeutic treatment and social and educational measures (Swiss Federal Council, 2002)

Swiss Federal institutions such as the Federal Office for Public Health (hereafter FOPH) and Swissmedic accordingly have no authority to restrict the prescribing practices of the medical profession. All they are entitled to do is issue recommendations. As the Council mentions, Swissmedic highlights the need for a 'holistic approach' regarding the phenomenon of ADHD. Yet, these recommendations are not binding and 'off-label' use of any medication is possible under the freedom in prescribing practices that medical doctors are endowed with.

Despite numerous political interventions (see **Parliamentary Database**, p.93), there has been a sustained reluctance on the part of the federal government for now almost two decades to actively intervene into the prescription practices of the medical profession in the context of ADHD. Arguably, this is not specific to the topic of ADHD. Rather, it reflects the power of the medical profession to define its own practice. Indeed, 'the privilege to prescribe' (Zola, 1977) in doctors, apart from the right to undertake surgery, particularly concerns the prescription of drugs. While cantonal (as opposed to federal) institutions have some responsibility regarding the monitoring of prescription practices (cf. Swiss Federal Council, 2002), it is professional associations that are endowed with regulating these. Let us consider a more recent statement of the Council to emphasise the role of such associations:

[t]he specialist information approved by the Swiss Agency for Therapeutic Products Swissmedic, which was adapted in 2012 to the recommendations of the EU, as well as international guidelines provide the framework for treatment and the treatment is incumbent upon the duty of care and therapeutic freedom of doctors. Further treatment recommendations are the responsibility of the relevant professional associations (Swiss Federal Council, 2014, p. 3)

In this statement the power of doctors is quite visible. In response to ongoing debates in the parliament regarding over-diagnosis and over-treatment in the context of childhood ADHD, the Council refers to the 'therapeutic freedom' of doctors. If prescription practices were to be changed, then that would be the responsibility of 'the relevant professional associations'. This reflects the claim of Illich (1977) that the acceptance of doctors as a dominant profession is essentially a political event, and that doctors are basically a 'self-accrediting elite'. Arguably, though, medics are only part of a larger actor network that aims to promote the idea of ADHD and its best treatment. It is this larger network of actors that this exploration now turns to.

## **Wider Actor Network**

In order to map the main actors in the Swiss discourse around ADHD I will briefly introduce a series of 'counter-discourse' (Jäger and Maier, 2010) texts,



i.e. newspaper articles that challenge the dominant understanding of ADHD as a brain-based deficiency in the child that needs to be treated with psychotropic drugs (cf. Biederman, 2005), as well as two complaints that have been filed in response to these texts. The image above (of the practice room of a general practitioner), and the article it relates to, are part of that series which is unique in that it offers a substantive critique on the discourse in Switzerland. While single instances of counter-discourse may be found throughout the data, this series brings together eight articles, published between the end of February and the end of March 2009, that consequently problematise the regime of practice around ADHD in Switzerland.

The series of articles criticises the significant increase (800% between 1995 and 2008) in prescription rates of Methylphenidate (Thiriet, 2009a), proposes alternatives to medical interventions regarding 'ADHD' (Fossgreen, 2009) and identifies a number of actors who contributed and continue to contribute to the popularisation of ADHD and its treatment with psychotropic drugs. Particularly the role of key opinion leaders (Thiriet, 2009b), the pharmaceutical industry (Thiriet, 2009c), general practitioners (Habicht, 2009a), the parents' advocacy association Elpos (Thiriet, 2009d), teachers (Habicht, 2009b; Thiriet, 2009e) and parents (Habicht, 2009a) are problematised. The claim that these actors play important roles in the popularisation of ADHD reflects findings of sociological research about the main drivers of the ADHD phenomenon, particularly in the US but also generally in the minority world, that I have discussed in the literature review (see **Central Drivers of the ADHD Phenomenon**, p.40). Let us briefly consider the critique these articles raise.

Drawing on a study conducted at the University of Bremen on the influence of parent advocacy organisations in Germany, the above-mentioned counter-discourse texts argue that Elpos is spreading awareness about ADHD and its treatment with psychotropic drugs. While increasing prescription rates may not be its primary goal, its activities, it is further suggested, have arguably led to a massive increase in children being medicated for behavioural reasons. In

a similar vein, the role of the pharmaceutical industry is problematised by pointing to some of its activities, such as financing key opinion leaders, publishing children's books on the topic, sponsoring TV shows and articles in health magazines. Against this critique, it may be concluded that while direct-to-consumer advertisements are not allowed in Switzerland as opposed to e.g. the US (cf. Abraham, 2010), the pharmaceutical industry arguably found other channels to market its drugs (see, for example, Albrecht, 2001).

Furthermore, teachers are described as those putting a lot of pressure on both children and their parents towards medical treatment for deviant behaviour. This concerns behaviour displayed both in the classroom and in other educational settings. For example, teachers may insist on drugging individual children to control their behaviour during day excursions and school camps. Teachers, it is further argued, are seeking to subject those children to pharmaceutical interventions in order to increase safety and to avoid risk. In a similar vein, however, parents may also be the source of pressure towards prescribing medication. The series of counter-discourse texts claims that general practitioners, as opposed to specialised medical professionals such as psychiatrists and paediatricians, would often prescribe psychotropic medication too frivolously because of pressure on the part of parents.

Finally, the articles problematise the collaboration between these actors. For example, the close ties to the pharmaceutical industry of one of the most renowned key opinion leaders in the field, who is simultaneously the co-president of the Swiss Society for ADHD (hereafter Society), have been criticised. I will, though, elaborate upon these collaborations against claims of neutrality and objectivity in the next section. Based on the critique raised by the series of counter-discourse texts mentioned above, the following actor network may be drawn:



Figure 10: Network of actors driving the ADHD phenomenon

I have used arrows to indicate the main direction of influence between actors. However, it may be argued here that in some instances these links may well be bi-directional. For example, medical doctors may present themselves as ‘experts’ in the identification and treatment of ADHD and, through advertising their services, also influence parents.

Arguably, key opinion leaders play an important role in that they collaborate closely with several actors. First of all, they are often funded by the pharmaceutical industry to disseminate research findings that shed a favourable light on the efficiency and safety of pharmacological interventions. Through holding important roles, such as being a vice president of the Society, and through close collaboration with advocacy associations such as

Elpos, they arguably influence individuals and organisations alike. The network of actors above (see Figure 10) also indicates their relationship with the FOPH. The dotted line, however, aims to indicate the rather passive role of the FOPH in spreading the 'knowledges' and 'truths' around ADHD.

However, as has been indicated in the literature review (see **Deregulatory Policies**, p.45), the ideology of the regulatory state significantly shapes prescription patterns. For example, sociological research indicates that the introduction of slow release amphetamines led to significant increases in both diagnosis and treatment of ADHD (Conrad and Bergey, 2014). Arguably, in the case of Switzerland, it is not so much the active involvement of the FOPH to promote the idea of ADHD but the liberal regulatory approach that contributes to the popularisation of the medical treatment of 'deviant behaviour' in children. This links with what has been described in the governmentality literature as 'de-governmentalisation of the state' (Rose, 1996, p. 56). In the light of advanced liberal rationalities that emphasise pluralisation, self-help, autonomisation and individual choice, the State increasingly detaches itself from many of the regulatory mechanisms and delegates them to a network of decentralised actors, including individuals, associations and agencies. Through complex processes, power is increasingly shifted to quasi-autonomous, non-governmental actors, including Elpos and the Society.

In the wake of these shifting power relations, members of the hegemonic discourse around ADHD position themselves as 'experts' in the light of specific knowledges that I have elaborated upon throughout this chapter. In particular, there is a certain 'emphasis upon the apparent objectivity and neutrality of numbers' (Rose, 1996, p. 56) such as the claimed prevalence rate of ADHD or the rate of its heritability. It is this emphasis that underpins the claim of individual experts and organisations that they are neutral and independent. Let us briefly examine these claims.

## Claims to Neutrality and Objectivity

As I have mentioned in the literature review (see **Consumerism and Advocacy Groups**, p.42), the parents' advocacy group Elpos is well known for its awareness raising campaigns regarding ADHD. Founded in 1974, this association has been successful in popularising the idea of 'Psycho Organic Syndrome' and, more recently, of 'ADHD'. In its overall concept Elpos argues that it is 'independent and neutral' (Elpos, 2018, p. 1). In the same document, though, Elpos argues that one of its objectives is the 'the cooperation with specialists and the SFG ADHS [i.e. the Society]' as a means to 'enable a well-founded and up-to-date transfer of knowledge' (ibid., p.1).

Moreover, from 1997 onwards Elpos has been funded in part by the Swiss Federal Social Insurance Office. Being funded by a governmental organisation and collaborating closely with the Society may not necessarily be supportive of the claim to 'independence and neutrality'. Rather, its interactions with these organisations may be interpreted as strategic acts in which 'truths' (such as the neurobiological nature of ADHD and its prevalence rate) are being used as tactical elements in the context of power relations within the 'regime of truth' around ADHD (cf. Lorenzini, 2015). Additionally, this reflects the tendency of activists to enlist the support of experts, including medical doctors, who are believed to have special qualifications that enable them to talk about causality and consequences regarding a topic that has been discursively established as a 'problem' (Best, 2001).

The close collaboration of Elpos with the Society is highly visible throughout its work. For example, in all three collections of articles that Elpos published there is an introduction on 'facts, terminology and criteria' around ADHD that makes a direct reference to the Society: '[t]his article has been reviewed by a member of the Swiss Society for ADHD for technical accuracy' (Elpos, 2016b, 2016c, 2016a). Furthermore, a key opinion leader and then co-president of the Society has published twice in Elpos' collection of articles, arguing that methylphenidate is highly beneficial (Ryffel, 2016a), not only for 'hyperactive' but also for 'hypoactive children' (Ryffel, 2016b). Hence, the

relationship between the Society and Elpos seems to be mutually constitutive. Elpos invites members of the Society to contribute articles to its publications, offering them a platform to raise awareness about drug-based treatments of ADHD. In return, the Society raises awareness about Elpos and its activities (see, for example, SFG ADHS, 2016b).

While the Society is transparent about its close ties to the pharmaceutical industry and its popularisation of a number of pharmaceutical drugs to treat ADHD (see **The Swiss Society for ADHD**, p.50), Elpos decidedly depicts itself as independent and neutral. In a complaint filed with the Swiss Press Council (2009) in response to the critique raised by the critical series mentioned above, Elpos highlighted that it was an independent organisation of concerned parents and would not advertise products of the pharmaceutical industry. Rejecting the ‘untrue and distorting’ portrayal in the newspaper article (cf. Thiriet, 2009d), Elpos argued that it would only be natural to inform members and the wider public about the topic and to exchange with ‘well-established experts’ (Swiss Press Council, 2009).

However, when Elpos depicts itself as an ‘independent organisation of concerned parents’ this does not necessarily constitute a denial of a conscious and intended promotion of pharmaceutical interventions in ADHD. Rather, it may be argued here that single members of Elpos, being part of a wider actor-network, may not necessarily be aware of the ‘supra-individual’ nature of discourses (Jäger and Maier, 2010, p. 38). While all individuals co-produce discourse, no single individual or even organisation has complete control over the way a discourse evolves.

Moreover, discourses transport more knowledge than individuals are aware of. The wider network of actors may, therefore, be understood as a ‘thought collective’ (Fleck, 1979). This collective creates knowledge in the light of common values and beliefs, so-called ‘thought styles’ (ibid.). The crucial point here is that an individual, such as the representative of Elpos arguing within the context of the complaint mentioned above, is not necessarily conscious of the current thought style and consequently may well see themselves as more

independent of other members of the thought collective than they effectively are. Nevertheless, these knowledges are presented as 'truths', and it is the reference to such truths that aims to transform highly political agendas into apparent apolitical ones and to endow those acting in the name of such organisations with apparent neutrality.

However, the members of such a 'regime of truth' do not act in a vacuum. Rather, they draw upon relations of power and knowledge in order to popularise certain understandings around ADHD while simultaneously suppressing others. In doing so they aim to establish the limits of what is legitimately sayable about ADHD. It is to these 'discursive limits' (Jäger and Maier, 2010) that the examination now attends.

## **Discursive Limits**

The series of critical articles discussed above provoked not only Elpos to file a complaint with the Swiss Press Council. In a similar vein, the key opinion leader who promoted the use of psychotropic drugs in children in two articles published by Elpos (see above) filed a complaint in his then held position as co-president of the Society. Let us briefly consider the main arguments the complainant brought forward. While the focus of Elpos was to highlight its own independence, the key opinion leader argued that the series of articles was 'one-sided, tendentious and partly slanderous' (Swiss Press Council, 2010). He continued by claiming that many facts the articles were drawing from were interpreted in a 'tendentious, one-sided and malicious way' (ibid). The claimant further criticised that the author of one of the counter-discourse articles did not disclose the 'dubious sources of information' that he was drawing upon. He asserted that these sources were known to him, and that they were a former activist of the Association for the Promotion of Psychological Knowledge of Human Nature (hereafter VPM) and a representative of ADHD Switzerland. Above that, the claimant argued that the 'alleged wire-puller' of the whole series, the representative of ADHD Switzerland, had been given the opportunity to publish a letter to the editor anonymously, and that this was against the directives of the Swiss Press

Council. He further argued that the series of articles had suppressed important information, 'for example the main reason for the boom in the prescriptions of Ritalin', namely the 'backlog demand' during a situation of 'continuing clear undersupply' (ibid.)

This points to what Jäger and Maier (2010) call 'discursive limits'. Rhetorical strategies such as defamations, relativisations, prescriptions, implicatures and allusions are used to narrow down or extend discursive limits. The complaints filed by both Elpos and the Society thus indicate that the critical series of articles had pushed the boundary of what could legitimately be said about ADHD. Let us briefly consider the strategies chosen by the claimant to maintain these discursive limits.

### **Defaming Those Raising Critique**

First, the key opinion leader chose to defame the author of some of the critical articles by degrading his work as being 'one-sided, tendentious and partly slanderous'. Additionally, the same author was blamed for using anonymous sources and accused of violating the 'privacy and personal integrity' of the claimant. According to the Declaration of the Duties and Rights of the Journalist, letters to the editor 'cannot be published anonymised without justification, examples of which can be protection of privacy or sources' (Swiss Press Council, 1977). If they are published anonymised, then that indicates that certain statements cannot be made without risking negative sanctions (Jäger and Maier, 2010).

However, through filing a claim with the Swiss Press Council the complainant found a way to expose an informant who preferred to remain anonymous, by linking him to an organisation. The claim mentioned the website of ADHD Switzerland, which is operated by a single person. Hence, through the report of the Swiss Press Council, which is accessible publicly, the identification of that person who aimed to remain anonymous had finally become possible. As a member of the counter-discourse, this individual is arguably vulnerable to tactics of the dominant discourse, including allegations and denunciations. In this case this included alleging that the person was the 'wire-puller' of the



whole series, and depicting the series as ‘tendentious, one-sided and malicious’. Therefore, a common strategy of the members of the dominant discourse seems to be to defame members of the counter-discourse. This confirms previous research findings that I have discussed in the literature review (see **The Voice of ‘Experts’ in Medicine**, p.47), highlighting how professionals find themselves both ignored and insulted if they question hegemonic practices in the context of ADHD.

### **Assigning Critique to ‘Anti-Psychiatry’**

A further strategy chosen by the key opinion leader was to marginalise opposing voices through assigning those voices to the ‘anti-psychiatry’ movement. In this case this has been achieved by relating one of the opposing voices to VPM. Founded in 1986 and dissolved in 2002, VPM saw itself in the tradition of Alfred Adler's individual psychology, cultural anthropology and developmental psychology and advocated for a move away from disease-oriented approaches towards approaches that put the individual into focus (cf. VPM, 1993, 1992). This arguably challenged, to a certain extent, the ideals and practices of contemporary psychiatry. Such organisations are treated by the hegemonic discourse as ‘anti-psychiatric’, although it may well be argued here that VPM was a member of the ‘critical psychiatry’ discourse (cf. **Critique of Psychiatry**, p.54) rather than the anti-psychiatric one. As Duncan Double argues, though, the label ‘anti-psychiatry’ is commonly ‘used within mainstream psychiatry in response to criticism which it does not accept’ (2019, p. 61).

This assigning practice is a particularly strong strategy. It has been successful in discrediting members of the counter-discourse, even on a high political level. Significantly, this strategy has been used to discredit the work of the United Nations Committee on the Rights of the Child (hereafter Committee). As I have mentioned in the introduction (see **Background**, p.1), the Committee criticised the practices around childhood ADHD in Switzerland in its concluding observations (Committee on the Rights of the Child, 2015). Yet, in a newspaper article (Schirm-Gasser, 2015b), the critique of the

Committee has been linked to a report written by the Citizen Commission of Human Rights (CCHR). CCHR is an organisation founded by members of the Church of Scientology and Thomas Szasz, one of the foremost members of the 'anti-psychiatric' discourse. Even though Child Rights Network Switzerland expressed similar concerns in its report (2014), which the author of the newspaper article titled 'Scientology denounces Switzerland at the UN' (Schirm-Gasser, 2015b) mentions in passing, the main focus of the article lies on the report submitted by CCHR. The article argues that

the UN is attacking Switzerland. And it does this with information from the kitchen of {aus der Küche von} Scientology (ibid.)

This argument is then further strengthened with a statement made by a representative of Elpos:

[t]he fact that a UN committee relies so heavily and uncritically on a Scientologist report is very irritating (ibid.)

Through this rhetoric the whole work of the Committee, including its recommendations regarding ADHD, has been discredited and, simultaneously, the hegemonic discourse been strengthened.

### **Affiliating Oneself to the Circle of Experts**

Finally, the key opinion leader chose to affiliate himself with the circle of 'experts', and thus with those that 'know'. Through claiming that there was a 'backlog demand' during a situation of 'continuing clear undersupply' (see above), he refers to the 'truth' of the epidemiological nature of ADHD that I have elaborated upon earlier in this chapter. Through aligning himself with such knowledges and truths, the claimant aims to endorse himself with credibility and authority.

### **Summary**

The final section of this chapter has elaborated upon how relations of power and knowledge endorse certain actors within the 'regime of truth' around ADHD with credibility and authority, while simultaneously discrediting others.

I have argued that key opinion leaders play an important role in popularising ADHD. Furthermore, medical doctors, through their 'privilege to prescribe', associations, and teachers are all part of the wider actor network that popularises the concept of ADHD and its medical remedies. Of importance here are the claims to neutrality and objectivity of these actors. Such claims aim to endorse those who 'know' with credibility and authority. The section has concluded with an elaboration on how discursive limits aim to limit what can legitimately be said about ADHD. I have argued that the maintenance of these limits includes strategies that marginalise opposing voices, including defamation of those raising these voices and assign them to the 'anti-psychiatric' discourse.

To conclude this chapter, the next section draws together the key findings of this first empirical chapter.

## **Conclusion**

This first findings chapter has focused on the knowledges and 'truths' that aim to render children governable and amenable to political programming. Numbers are an important part of these 'truths', and a particularly strong means to raise public attention towards certain issues that are rendered problematic. The findings highlight the key role that the supposed prevalence rate of ADHD plays in legitimising current discursive practices, including the mass drugging of children. Against epidemiologic models and logics, numeric 'truths' are employed to predict the number of children who are affected by ADHD. I have argued that previous research has indicated that the prevalence rate of ADHD varies significantly, both within and across geographical regions. However, meta-regression analysis i.e. complex statistical manipulations of weighted data have enabled researchers to establish a worldwide prevalence rate of childhood ADHD of 5.29 per cent (cf. Polanczyk et al., 2007). The elaboration of the evidence that this claim is based upon, however, has revealed that the statistical manipulation relies on the isolation of variables that significantly shape the prevalence rate across the studies scrutinised in the meta-regression analysis, including the

diagnostic criteria and sources of information used in diagnostic process. Hence, it may be argued here that this number does not account for the diversity in diagnostic processes and clinical practices found around the globe by isolating these variables. Rather, it establishes an artificial number that is then being used for political purposes. Once established, that number has become a norm against which all actions should be measured. Arguably, this number impressively represents the entanglement of power and knowledge in that it enables the maintenance of discursive limits: those who 'know' (Foucault, 1991b) refer to it to endow themselves with credibility and authority, while those who oppose it are being marginalised. ADHD and its supposed prevalence rate are therefore presented as epidemiologically substantiated discoveries. The reference to the prevalence rate of five per cent presents the claim as a 'given truth' (Tait, 2006), and only prescription rates beyond this rate would be regarded as abusive because everything within this epidemiological prognosis is simply being expected. Hence, the prevalence rate arguably becomes, to a certain extent, a self-fulfilling prophecy, blurring the complex social, cultural and economic factors shaping the lives of individual children and reducing their lived experiences to a single number.

Building on this epidemiological prognosis, the hegemonic discourse then establishes ways to diagnose ADHD. Drawing on Fleck (1979) and his concepts of thought style and thought collective, the analysis has scrutinised the latest German guideline *Attention Deficit / Hyperactivity Disorder (ADHD) in Childhood, Adolescence and Adulthood* (DGKJP et al., 2018a, hereafter *Guideline*). Such guidelines aim to support professionals in the process of inference, i.e. in reaching conclusions in clinical practice. The exploration of the *Guideline* reveals that vade mecum science (Fleck, 1979) rather than journal science was used here as the basis for the development of what is being regarded as the highest standard of 'evidence based' guidelines. Using the claim to the genetic basis of ADHD as an example, the elaboration highlights how rather vague research findings became translated into vade mecum science, allowing for a much more favourable interpretation and

conclusion. This was then further translated into popular science that presents the initial vague and contradictory findings around heritability into a given 'truth'. Moreover, the findings have highlighted that the recommendations are predominantly based on consensus regarding 'best clinical practice' without reference to research. While the methodological assumptions and decisions, as well as the processes that led to consensus, are well documented and follow agreed criteria, the quality of the evidence, and hence the claim to the 'scientific base' of the *Guideline*, seems to be rather questionable. This arguably demonstrates the power of professions to define their professional practice. The results have also illustrated the utopian character of contemporary rationalities of government by indicating the numerous problems the Guideline aims to address, including reducing school dropouts, delinquency and suicides, and increasing the average level of both socio-economic status and educational degree achieved in later life. This utopia consequently assumes that we can draw upon a certain body of knowledge and pharmaceutical agents to reform human beings towards desired ends.

Building on the claims of epidemiology and guidelines regarding diagnosis, the hegemonic discourse suggests that the most appropriate way to treat ADHD is through pharmaceutical interventions. The question, though, of whether subjecting children to such interventions as a means to amend their behaviour is justified or not, is one of the strongest disputes in the discourse around ADHD. Nevertheless, the examination of the hegemonic discourse suggests that contemporary clinical practices affect an increasing number of children. The rationale here seems to be to intervene earlier i.e. in younger children and more comprehensively i.e. in cases of less severity. This is most visible in the *Guideline*. The exploration of this document has revealed that a considerable number of the recommendations (35 out of 84) are concerned with pharmaceutical treatment and that only four of these recommendations are based on scientific evidence. In addition, the authors of the *Guideline* admit that the mechanisms underlying the effects of stimulants are not yet known. Again, the assessment of the quality of evidence is based on vade

mecum science rather than journal science, and the positive representation of stimulants in terms of usefulness and safety is in stark contrast to more independent (in terms of links to the pharmaceutical industry) and critical research (e.g. Storebø et al., 2015). In summary, the 'regime of truth' around the use of psychopharmaceuticals in children labelled with ADHD seems to reflect the clinical preferences of the medical profession rather than being an intervention that is based on scientific evidence.

The findings indicate that the knowledges around ADHD, including the claim to epidemiology and the suggestions regarding diagnosis and treatment that are presented as 'truths' are entangled with power. It is these power relations that in turn limit what is sayable at a certain point in time. The results illustrate that the proliferation of ADHD in Switzerland depends on a network of actors, who all are members of the 'regime of truth', in which key opinion leaders play a pivotal role. The findings further illustrate the central drivers in the popularisation of ADHD, including the liberal regulatory approach of the State, the general tendency towards medicalisation of social problems and the role of the pharmaceutical industry. Furthermore, the role of the parents' advocacy organisation Elpos has been identified as being central to the popularisation of ADHD in Switzerland. The results further highlight that the Swiss Society for ADHD, as well as key opinion leaders, plays an imperative role in aligning the interests of the pharmaceutical industry with those of Elpos. The exploration of actors and the discursive limits they have established and maintain suggests that ADHD has been fully claimed by the medical profession as a legitimate medical problem rather than a social one. Those who have publicly challenged this notion have been denounced throughout the discourse. An important strategy of the hegemonic discourse is to align those opposing the current 'thought style' (Fleck, 1979) with the anti-psychiatric movement in order to discredit their claims.

This chapter has illustrated how 'truth' around ADHD is built to render children knowable and governable. The way we rationalise children, including developmentalism and biological understandings of their behaviour, arguably

has real consequences for their lives. Such knowledges and 'truths' both inform and are informed by idealised images of childhood. It is against such images that the governance of children is being performed. The next chapter will examine these images and the way they support the idea of ADHD and its remedies

## 5 Conceptualising Children Alongside Idealised Images of Childhood

*«Because a child diagnosed with ADHD isn't seen as being naughty or deprived, he neither needs to be punished nor offered social support»*

Steven Rose (2005, p. 258)

### Introduction

The previous chapter examined the knowledges and 'truths' around ADHD that seek to render children both knowable and governable. This chapter builds on these insights and is guided by the second specific research question, i.e. 'how are children labelled with ADHD conceptualised and represented?'. This chapter draws on the pictorial representations of children that aim to problematise those labelled with 'ADHD' in the light of a particular understanding of children and of childhood. In terms of theory, in addition to the general governmentality orientation that runs throughout this thesis, this chapter particularly draws from the new social studies of childhood and its concern with constructions of children and childhood that I have discussed in the literature review (cf. **Images of Childhood**, p.26).

My visual demonstration of the media plane regarding the representation of children in the discourse on childhood ADHD in Switzerland yields a strong emphasis on portraying boys and their (often 'deviant') behaviour. In representations that either depict only one child (37 in total) or where a particular child is in focus (8 in total), 35 depict boys and only 10 depict girls. I argue that the conceptualisation of children as advanced liberal subjects is built along three main pictorial representations. First, 'deviant' or 'abnormal'



behaviour in children is depicted, such as the child having a tantrum, the child fidgeting, or the child being inattentive. Second, the 'deviant child' is depicted as distressed, allowing the construction of the ill rather than bad child. Finally, the image of the well-behaved child aims to highlight a core value in contemporary constructions of childhood in the minority world: the self-regulating child. Consequently, this chapter is organised around these three themes, i.e. representations of deviance, distress and self-governance.

In terms of data, each section presents an image that I have identified as representative of the relevant theme. As described in the introduction to the previous chapter, I carefully read through all my data (i.e. texts from the media, the political and the parents' advocacy discourse planes) and coded texts that were relevant to each theme. A total number of 64 texts were coded to the theme Representations of Deviance, 33 to Representations of Distress and 29 to Representations of Self-Governance. Based on these texts I then undertook an in-depth analysis in order to identify sub-themes. Within these sub-themes, I coded aspects that were constitutive of that subtheme. For example, for the main theme 'Representations of Self-Governance' I identified Performing Advanced Liberal Subjectivity as a sub-theme and Reflexive Thinking as one aspect (amongst others) of that sub-theme. Out of that analysis I then identified 37 text fragments as representative of these sub-themes. Most of these fragments refer to more than one aspect of the relevant sub-theme. In terms of discourse planes, 23 fragments are from the media, twelve from the parents' advocacy and one from the political plane. Moreover, one fragment is taken from the *German Guideline on ADHD* (DGKJP et al., 2018a) that was discussed in the previous chapter.

Let us now turn to the findings, beginning with representations of deviance.

## **Representations of Deviance**

This section briefly elaborates upon how deviance is being defined in the discourse around ADHD, which is followed by a discussion on cultural and

political aspects of such definitions. Finally, some insights are offered into how risk is used to project future outcomes and, based on this, to manage the present.

## Defining Deviance



Figure 11: 'Outbursts of anger in children can be perfectly normal, says Allen Frances' (Straumann, 2013)

In order to manage populations they have to be known (Foucault, 1989). Arguably, contemporary governmental practices do so by dividing populations into categories (Tait, 2006), where ADHD is only one amongst many. Particularly on the media plane, discursive constructions of 'deviance' are built not only through text but also through pictorial representations,

including the image above. Showing a boy having a tantrum has the aim of familiarising the reader with the face of 'deviant behaviour'.

Providing a 'visual way in' (Banks, 2018) to the discourse around ADHD, such imagery aims to render children knowable based on their behavioural characteristics. This problematisation of certain behaviour reflects the categorisation of 'ADHD' as a 'behavioural disorder' (see APA, 2013) and is further substantiated throughout the discourse by descriptions of 'deviant' behaviour. Such descriptions seem to be particularly detailed in what may be termed vade mecum science (Fleck, 1979), including diagnostic handbooks, as well as in popular science, including the publications of Elpos that are elaborated upon throughout the findings chapters. Let us briefly consider both of these. Forming part of the latter, the account of a psychologist offers, in one of the publications of Elpos, a substantive description of what 'deviant behaviour' in children with ADHD is considered to look like. Such children, thus,

have great difficulty in focusing their attention (e.g. on the voice of the teacher) and not being distracted by the numerous external stimuli in a classroom... Silent activities, independent work and the many monotonous and repetitive tasks are also challenging for them. In addition, the homework situation is often perceived by the parents as particularly stressful. Here the dreaminess, the inattentiveness, but also the hyperactivity and impulsiveness of the children come to bear fully (Florin, 2016, p. 35)

Particularly problematised is the 'low attention span', which is believed to be leading to several behavioural problems. Accordingly,

pupils with ADHD have a small attention span and overlook details that seem unimportant to them, make many careless mistakes, show little perseverance, are easily distracted, face problems in structuring and organising tasks, have 'jumping thoughts', forget things in the daily routine, appear absent and dreamy in class and react with a delay to requests (ibid., p.35)

The author goes on to argue that such children

can hardly sit quietly for a long time, leave the place without being asked, walk around in the classroom, often disturb the lessons and their classmates, are excessively noisy and work extremely slowly... Furthermore, they have mood swings and a low frustration tolerance, are sometimes very curious, sometimes distant or have a high willingness to take risks and sometimes

show aggressive and angry behaviour. They disregard boundaries without noticing it or they can hardly react spontaneously to new situations and appear distanced in the class (ibid., p.35)

This long account provides a substantive problematisation of behaviour in children. The mentioned deviations from a 'docile body' of the child are monitored, assessed and finally opened to the medical gaze. Problematised behaviour, then, becomes translated into diagnostic handbooks such as the DSM-5. It is remarkable how closely the description of symptoms in such *vade mecum* literature reflects the 'problematic' behaviour described above. Taking DSM-5 as an example, diagnostic criteria include that a child with ADHD often 'fails to give close attention to details', 'avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort', 'fidgets with or taps hands or feet or squirms in seat', 'talks excessively', 'leaves seat in situations when remaining seated is expected', 'interrupts or intrudes on others' (APA, 2013, p. 59ff).

These problematised behaviours could be summed up as an under-performance in the area of what has been described as the 'executive functions'. Children labelled with 'ADHD' are believed to have differences in their brain structure that prevent them from performing highly in these functions (cf. Comstock, 2011). The reference to this 'scientific fact' (Fleck, 1979) can be found throughout the discourse. However, I will turn to executive functions later in this chapter, in the section on Representations of Self-Governance.

Once the behavioural patterns of a certain 'diagnosis' have been defined, they may then serve as an instrument to identify those believed to fulfil the criteria. The ascription of such diagnoses to children arguably leads to processes of labelling. While 'ADHD' is a label on and by itself, it is remarkable how many further labels are being used to describe problematised behaviour in the discourse around this phenomenon.

They include being volatile {unberechenbar}, unbearable, displaying behavioural problems {verhaltensauffällig}, being difficult, requiring therapy

{therapiebedürftig}, being antisocial, violent, problem-ridden {problembeladen}, cheeky, aggressive, disruptive, disobedient, annoying, wild, demanding, slow, delinquent, spirited {temperamentvoll} and stupid. Additionally, children are depicted as a 'problem child', 'risky child', 'monster', 'special-needs child' and 'naughty brat' {ungezogene Göre}. All these adjectives and nominatives are being employed in the discourse on ADHD and, arguably, have an effect on the children described. Through an iterative process they are part of a 'circumscription of individual pathology' (Dean, 2010, p. 219), defining the 'otherness' of children labelled with 'ADHD' against the wider population of children.

Such processes of ascription of characteristics arguably tend to stigmatise children. Through their iteration they contribute to the formation of the idea of deviance. Children labelled with 'ADHD', hence, are seen as 'deviant', which also has an influence on diagnostic processes. What is being assessed is their 'deviant behaviour'. It may be argued here that some remains of the image of the Dionysian child (Jenks, 2005) are still visible. This argument is substantiated by accounts of parents themselves who publicly admit that they think their boys are 'bad'. In a media article a mother said 'I thought to myself, my God, what kind of monster did I produce?' (Minor, 2007). In another article, the author suggests that

[a]nyone who has ever experienced a hyperactive child can guess what their family is going through. These children are annoying. Year in, year out. Sometimes even their own parents could 'slap them against the wall', as a father once said (Schneebeli, 2010)

Such accounts are also employed to argue for the medicalisation of children. In the article above the mother who referred to her child as 'monster' argues that before prescribing and administering drugs to her ten and eight-year-old sons, 'the world was a small hell, because both boys suffer from attention disorder ADHD' (Minor, 2007).

Prescribing drugs, therefore, may be perceived here as a means of punishment, to render the 'monster' (see above) 'loveable again' (Ciba-

Geigy, 1971, p. 108). However, against more recent shifts towards the Athenian image of childhood, it may be argued that such technologies of government are employed to render the child 'ill', rather than 'bad'. This conceptual shift is further substantiated through the emphasis on the distress experienced by such children, rather than on the 'badness' of their behaviour. I will turn to representations of distress, though, in the next section of this chapter.

Accounts like the one cited above suggest that the general approach to 'deviant' behaviour seems to be one of ascribing labels, both psychiatric and non-psychiatric ones, which in turn serve as a legitimisation for the prescription of psychotropic drugs. Yet both the definition and ascription of labels are not neutral but depend on the cultural context they are embedded in and the political processes they arise from. It is these cultural and political dimensions that the exploration now concentrates on.

### **The Cultural and Political Dimension of Deviance**

The image above, depicting a boy having a tantrum, is part of an article entitled 'To each [their] mental disorder' (Straumann, 2013). It problematises the DSM-5, arguing that with this latest release of the manual, everyone would qualify for at least one psychiatric disorder. In this article a psychiatrist contends that newly introduced diagnoses such as the Disruptive Mood Dysregulation Disorder may again lead to 'misdiagnosis in normal children who go through a phase or are simply temperamental' (ibid.). In a similar vein, based on an interview with a child psychiatrist, a journalist elaborates on the same diagnosis and argues that

[n]obody can stand a child who goes wild and screams three or more times a week. Frequency is a criterion for a new diagnosis. Which mother would not like to accept it, even if she immediately forgets its name 'Disruptive Mood Dysregulation Disorder'? The rage diagnosis is intended to reach children for whom no diagnosis did fit well (Schmid, 2013)

Having a tantrum, thus, is seen as pathological as soon as it takes place three or more times per week. This may be understood against the image of

the Apollonian child, which emphasises the angelic, innocent nature of children. As Jenks argues, it is against this image that we 'cannot abide their tears and tantrums', but only want 'the illumination from their halo' (Jenks, 2005, p. 65). The article explains that this new diagnosis has been defined in order to prevent over-diagnosis of bipolar disorder. This reflects the tendency to govern childhood through more and more diagnoses (Tait, 2006).

The claim that nobody can stand a child who frequently shows outbursts, however, reflects a cultural point of view. While in the German speaking part of Switzerland children are expected to perform well and to subordinate themselves to a regime of practice (Dean, 2010) that aims to maximise human capital at an ever earlier age, there seems to be a much higher tolerance of such acting-out behaviour in the Italian speaking part of Switzerland (cf. Ellner, 2013). Arguably, such cultural differences also play an important part in the five-fold higher diagnosis and medicalisation of 'ADHD' in the German speaking part of Switzerland as opposed to the Italian speaking part (cf. Hehli, 2018). In the French speaking part, these practices seem to differ less from those in German speaking Switzerland (ibid.). As I have indicated in the methodology chapter, these cultural differences are not reflected in the data by a stronger counter-discourse. Rather, the concept of ADHD seems to be simply less discussed and popularised in the French and particularly the Italian speaking part of Switzerland.

This is supported by the sociological and anthropological insights that I briefly introduced in the literature review (cf. **Culture**, p.59) and that suggest that both hyperactivity and disruptiveness are highly culturally constructed entities. There is evidence that this phenomenon is being repeated in Italy (cf. Conrad and Bergey, 2014). Such cultural differences, though, challenge the hegemonic discourse. As indicated in the literature review (cf. **The Voice of 'Experts' in Medicine**, p.47), one of the central elements of the current 'thought style' around the concept of 'ADHD' is the contention regarding its cultural neutrality.

But what happens if a child only rages and screams twice a week instead of three times – is the anger not pathological in this case? The child psychiatrist interviewed in the article cited above argues that

[w]hat is considered ill is always only an approximation and thus arbitrary in its tendency... One has to set limits for diagnoses: 'This is not a scientific, but a political decision' (Schmid, 2013)

Yet this 'political decision' has significant effects on the lives of children. It enables the very regimes of practice (Dean, 2010) around the definition and identification of 'deviant children'. In this context, behaviour, including frequent outbursts, is framed, labelled and discredited. Consequently, children displaying behavioural patterns that are considered 'disruptive' by their environment increasingly face a diagnosis that is aimed at addressing their conduct and changing it towards desired ends.

Against this backdrop, technologies of government (Rose, 1999) seek to translate current behaviour into future outcomes. Arguably, an important means to link a projected future with the present is through risk assessment and management (cf. Bailey, 2010). It is to these technologies that the focus of the elaboration now turns.

## **Risk Based Technologies of Government**

Once 'deviant behaviour' has been defined, it may then be used to identify those children who are seen as either at risk or being risky, or even both. As has been indicated in the literature review (cf. **Risk and Prudentialism**, p.22), technologies that may be best described as 'case management risk' (Dean, 2010) are employed in this context to combine epidemiological rationalities of risk interpretation and management with techniques of diagnostics and therapeutics. As has been argued in the previous chapter (cf. **The Evidence Basis of Recommendations**, p.132), the expected prevalence rate of 'ADHD' has been determined as five percent. Those judged 'at risk' are then subjected to a range of therapeutic, disciplinary and sovereign practices (Dean, 2010). This usually involves a range of



techniques including interviewing, psychometrical testing and the exercising of bureaucratic judgement in schools or clinical judgement by medics.

Against this backdrop, risk is sought to be attached to the bodies of individuals in order to render them amenable to more intensive surveillance and treatment (ibid.). This individualisation of risk is bound to advanced liberal government in the light of what may be termed an idealised image of the Athenian child (Smith, 2012). As O'Malley (1996) argues, such a 'rational and responsible individual will take prudent risk-managing measures' before taking any action. Consequently, risky behaviour is not only seen as unhealthy but as undermining the very project of the economic investment into the self (Dean, 2010). It is against this rationale that problematised behavioural patterns, as described above, have to be interpreted. This understanding of 'how to act best' is therefore in conflict with the behaviour displayed in children labelled 'ADHD'. This very behaviour, hence, serves to identify children as being 'at risk', and to make them a targeted population for governing their conduct towards specific patterns. As Rose (1999, p. 123) argues, '[c]hildhood is the most intensively governed sector of personal existence'. Arguably, children are seen as immature and in need of particularly intense government. Not so much the current effects of their behaviour are of concern here, however, but rather the future outcomes that are linked to them. In two of Elpos' publications the editors mention some of the risks that have been ascribed to undetected and untreated ADHD:

[e]arly detection and treatment: These are extremely important in ADHD. If the child always experiences [themselves] negatively and [do] not fulfil the school requirements, the development of a healthy feeling of self-worth and identity is hardly possible, which strongly impairs the further life. If ADHD symptoms are not detected or treated in time, the risk of co-morbidity (accompanying disease) or secondary disorder increases. Distress from tics, anxiety or obsessive-compulsive disorder, depression or thoughts of suicide can occur as early as in childhood, while eating disorders and addiction ('self-medication') can also occur in adolescents (Elpos, 2016b, p. 8, 2016c, p. 11)

Again, early detection and treatment are stressed, based on the assumption that they may prevent co-morbidities in the future. Ewald's (1991) framework enables linking such risk rationality to specific forms of expertise, identity and

agency. In the case of ADHD in children, certain behaviour (such as hyperactivity) is being linked with the idea of risks, particularly in terms of future outcomes, and interpreted and managed in the light of specific knowledge, such as the assumption of an imbalance in brain chemistry and the need to treat this with stimulants (cf. Hanan, 2019).

## **Summary**

To conclude this section, it may be argued that risk is employed as a set of ways of rendering reality calculable (Dean, 2010). In the context of children and mental health, this includes to define what 'deviance' looks like, and to enshrine these definitions into manuals to facilitate diagnostic processes. Such understandings of deviance, though, are not neutral. Rather, they are embedded into cultural environments and arising within political processes. An important aspect of such technologies of risk is the idea of predicting future outcomes and using these predictions to govern children's conduct in the present. Significantly, the discourse on ADHD offers a relief from viewing children displaying deviant behaviour as 'bad' through rendering them 'ill'.

Through emphasising the distress experienced, children who historically were considered 'bad' are now constructed as being 'ill'. It is to this conceptual emphasis on the distressed and ill child that the elaboration now attends.

## **Representations of Distress**

This section elaborates upon how individual distress in children both offers an alternative to the 'bad' child (see previous section) and mediates medical interventions. In this context distress serves both as a rationale to substantiate the discursive shift from 'bad' to 'ill' in understanding children's 'deviant behaviour' and to legitimise medical intervention to manage children. Let us consider this shift.

## From Unwilling to Unable

The following series of images was published with the caption 'Children with ADHD have great difficulties in learning' (Leuenberger, 2010).



Figure 12: 'Children with ADHD have great difficulties in learning' (Leuenberger, 2010)

The series shows a boy trying to work himself through scholarly tasks. The top left image shows the boy holding a pen in his left hand, but in a way not suitable for writing. Then, in the top right image, the boy holds the pen in his right hand. It looks like he is playing around with it. In the bottom left image, the boy leans back, giving way to his growing frustration. Finally, in the bottom right image, the boy turns himself completely away from the worksheets.

It remains unclear whether these pictures were meant to represent schoolwork or homework. The tablecloth on the top left image, and the chair, though, are reminiscent of a private home rather than a school environment. Either way, the images seem to seek support for the claim that children labelled with ADHD 'have great difficulties in learning'. Yet, this may be at

least in part misleading. Some children may have great abilities to learn but may be distressed in learning environments that do not suit their needs and strengths. This will be elaborated upon in the next section of this chapter. The article itself was published under the title 'Children with ADHD do not know what they are doing', and problematises that they often respond to questions without waiting their turn. The main argument of the article is that children would like to subject themselves to the disciplinary regime in schools but are not able to do so. It is on this contention that the examination now concentrates.

As discussed in the last section, deviance has been interpreted through the lens of risk and this has consequently produced the idea of the child both being at risk and being risky. However, through the emphasis on distress the child is being freed from 'badness' through the ascription of pathology. Against this discursive construction, the inability to perform according to the standards set by contemporary schooling is being re-interpreted as a form of illness. Rather than being unwilling (which is considered 'bad' and a moral judgement), children are constructed as being unable (which is considered 'ill' and a clinical judgement) to strive in common school settings.

The article around the image discussed above was published with the title 'Children with ADHD do not know what they are doing'. It elaborates on the inability of some children to suppress their impulses:

'How much is seven times six?' the teacher asks the second graders at the end of the school year. The hands fly up as it should be. A boy screams: '42.' The teacher admonishes him for the umpteenth time to obey the rules. But the boy can't.

When he knows something, it bursts out of him. 'Increased impulsivity - sudden, violent, even planless actions - is one of the conspicuousities that are at the centre of attention/hyperactivity disorders (ADHD),' explains [the interviewee], head physician at the Children's and Youth Psychiatric Clinic at Basel University Hospital...

Does the second grader suffer from ADHD because he immediately says what he knows and cannot wait until the teacher asks him to do so? 'Not necessarily,' says [the interviewee]. 'Because we actually want children who are not anxious and inhibited, but spontaneous. But when the 'fresh way'

reaches a level that society no longer tolerates, there are problems: The children get kicked out of school class or sports club, the piano teacher no longer wants to work with them, they have no friends.

'The diagnostic criteria for ADHD are also in this area of conflict,' explains child psychiatrist [name of the interviewee]. 'The transitions between normal and disturbed behaviour are fluid (Leuenberger, 2010)

The article thus describes a typical school situation. All children are asked to calculate 'seven times six' but then keep the result to themselves, raise their hands and wait their turn. Hence, if a child does not follow this procedure they do not 'obey the rules' and therefore show 'deviant behaviour'. Rather than labelling the child as disobedient and dangerous, though, the article concludes that the boy cannot follow the rules, hence offering an alternative to the 'bad' child: the 'ill' child who is willing but unable to perform according to expectations. This argument is built up by referring to the 'scientific fact' (Fleck, 1979) that 'increased impulsivity - sudden, violent, even planless actions' are core characteristics of children labelled with 'ADHD'.

The reference to school dropout, problems during free time activities and the absence of friends additionally points to the high distress these children experience. Yet, as the consulted child psychiatrist argues, a certain level of spontaneity in children is actually appreciated in contemporary cultural norms and understandings in Switzerland (and similar cultural settings), while anxious and inhibited behaviour is considered pathologic and open to therapeutic intervention. Children are thus encouraged to be outgoing. However, as Rose (1999) suggests, if they are too outgoing or not outgoing enough, then this is rendered problematic. As Foucault (1989, p. 20) argues, phrases like 'increased impulsivity - sudden, violent, even planless actions' imply both judgments of normality and attributions of causality. Based on such constructions, technical interventions for normalisation processes are then installed. Since the line between too outgoing and not outgoing enough is debatable, and dependent on the cultural norms and values of a specific society at a specific time, the same level may be appropriate in one context but not in another (see also the discussion on deviance above).

As the consulted child psychiatrist argues, 'the transitions between normal and disturbed behaviour are fluid'. However, the article also offers a 'label of forgiveness' (cf. **The Shift from Psychoanalysis to Pharmacology**, p.35) by pointing to recent research that has been undertaken at the University of Bern, Switzerland. The article contends that

[r]esearchers in Bern have discovered that the brain of ADHD children triggers rapid reactions before any awareness of this reaction can develop (Leuenberger, 2010)

The design of the referred-to research included 17 children diagnosed with ADHD and a control group of equal size. The research participants were subjected to a 'continuous performance test' over a period of 40 minutes and their brain waves were recorded and analysed by an electroencephalogram. The main argument derived from the research findings was that those children labelled with 'ADHD' have such strong impulses that when their consciousness sets in, the damage is already done. Hence their behaviour is assigned to an independent actor, their 'ADHD', which determines their behaviour before they even realise it. Hence, such children are not 'bad'. Rather, they suffer from a condition that determines their behaviour. Considering a recent critique of the technologies used both as a way to measure brain activities and to process and interpret such measurements (Hasler, 2013; White and Wastell, 2017), though, the hypothesis that children are determined in their behaviour before they even realise it is rather questionable.

However, the psychologist who led the research project also offers a different perspective on the unconscious behaviour believed to be found in 'impulsive children'. She argues that there might be a possibility of using her findings in therapeutic practice to replace

not intentionally planned, unwanted behaviour with completely new patterns, strategies and rituals. But practicing and re-learning is an exhausting, lengthy process that requires a lot of awareness and attention (Leuenberger, 2010)

This statement, at last, offers a different perspective on being too impulsive and determined by one's own behaviour. Interestingly, the statement does not seem to support the hegemonic discourse, as reference to the use of medication in such children is missing. Rather, a re-learning process is suggested to develop 'new patterns, strategies and rituals'. Such an approach would also take into account the plasticity of the brain (Hopf, 2015; Schmidt, 2019) and support these children to learn new behavioural patterns through pedagogy (Wittwer, 2019) rather than suppressing their old patterns through pharmaceutical interventions. This also links with insights from epigenetics (cf. Wastell and White, 2017). However, focusing on plasticity rather than determinism may lead to efforts to optimise a child, as all difference may be considered suboptimal and open to intervention, particularly in young children (ibid.).

While there are references to plasticity and the usefulness of alternatives to pharmaceuticals, medical interventions are the predominant means of addressing 'ADHD' in contemporary discourse. Stories often describe the high value of prescribing stimulants. In a media article a mother writes about why administering Ritalin to her two sons is a 'blessing'. Without these pharmaceuticals, she argues, 'a regular everyday life would be unthinkable' (Minor, 2007). She describes that when she took her older son to the paediatrician, he was

fidget[ing] hectically with his legs in the practice and said desperately: 'I don't want that after all. That just makes it with me' (Minor, 2007)

The reference to 'it' in this context suggests that there is an agent out of the control of the boy. Arguably, this hidden agent is filled, in the hegemonic discourse, with the idea of 'ADHD' and the effects on the human brain it brings. In line with these discursive practices, the main argument of the article is that both children have no control over their bodies, unless they subject themselves to the influence of stimulants. When asked whether more physical activity would help her two sons diagnosed with 'ADHD' to gain more control over their bodies and impulses, the mother argues that

[o]ur boys stand in their own way. Their bodies cannot do what the brain would like them to do. That makes them angry. There's no use running around in the woods – there they would be standing in their own way, too (ibid.)

The lack of control over one's body is therefore described as twofold. On the one hand, the 'body' is performing things, including fidgeting with its legs, without prior conscious planning by the 'brain'. On the other hand, conscious planning and coordination of bodily performance are described as not possible, since 'their bodies cannot do what the brain would like them to do'. In an earlier article on the same story, the mother argued that the frustration regarding the lack of control over the body was observable as early as during infancy:

[a]nd then there were the tantrums. The mother remembers that Max lay in his playpen and trembled heavily. Today she knows that this was 'the sheer rage of the brain on the stupid body': Max wanted to turn onto his stomach, but his limbs did not obey. That brought him into an indescribable rage (Schuler, 2005)

As the main focus of these two articles is on the usefulness of prescribing Ritalin to children, the outcome is also described in these terms: 'since he can control his illness thanks to Ritalin, he draws much, gladly and well' (ibid.). Both articles thus aim to suggest that the children described are not unwilling to perform according to normalised expectations and standards of their environment. Rather, they are unable to do so. However, there is a solution called 'Ritalin' that renders their bodies controllable. While there are several situations described throughout the articles in which the boys suffer from a lack of control over their bodies, the (through medical interventions gained) ability to draw in one of the boys is particularly emphasised:

the most obvious change for everyone was that Max, who had hardly ever touched a coloured pencil before, suddenly began to draw. And how! As if he had to catch up on the years of missed creativity, he filled boxes with his drawings (ibid)

Hence the gained ability of the boy to draw 'much, gladly and well' is ascribed solely to the prescription of Ritalin. Not only does the drug render the body under the control of the boy, the article contends, but it also unfolds the



inherent creativity of the boy. I will, however, expand on the possible links between 'ADHD' and creativity in the next section of this chapter. The two stories are clearly written to highlight the 'blessing' a prescription of Ritalin can bring. This is emphasised in the title of one of the articles, which reads 'How a Ritalin child masters his life'. The whole identity and personality of that child is therefore reduced to being a 'Ritalin child', and the prescription of that drug is legitimised through reference to individual (the child) and collective (the environment) distress. I will now elaborate on this link between distress and medicalisation.

## **Distress as a Decisive Element**

The *Guideline* that has been examined in the previous chapter (cf. **The German Guideline on ADHD**, p.128) suggests that

[t]he choice of therapy should take into account personal factors (e.g. distress), environmental factors, the severity of the disorder, the coexisting disorder and participation (DGKJP et al., 2018a, p. 44)

When analysing the discourse, the single most decisive element, though, seems to be distress {Leidensdruck} in the child and particularly in his or her environment. Rather than seeing a child labelled with 'ADHD' as unwilling to perform according to expectations and in need of punitive interventions to 'revive for the lazy individual a liking for work' (Foucault, 1989, p. 122), or simply regarding them as badly educated (cf. Donzelot, 1980), the discourse offers the conceptualisation of the 'ill' child through the emphasis on 'distress'. A journalist reporting on a documentary produced and published by Swiss National Television SRF argues, rather emotionally, that while watching this movie 'one suffered with the child' (Jeitziner, 2005). In order to substantiate her statement the journalist described the distress in the boy:

[t]he slim boy is fidgety, has problems at school, and fears of failure. The camera was there when he suddenly threw a tantrum {austickte} on the school square and slapped two students, although both were at least one head taller and one third heavier. It was sad to see him almost crushed by the burden of illness and getting lost in the shuffle {wie er unterging} of the integrative school (ibid.)

The focus in this statement is clearly on the distress experienced by the boy rather than the 'deviant behaviour'. Offering an alternative to the 'bad' child as represented by the Dionysian image (Jenks, 2005), the boy is described in terms of the burden his illness is causing him, and the reader is asked to feel pity rather than anger. The idea of the ill, distressed child thus lays the ground for medical intervention, legitimised by the moral obligation to alleviate distress.

In an article published by Elpos, a teacher and vice president of the Swiss Teachers' Association argues that

[n]o one, no teacher, no parent and no paediatrician wants children to be prescribed medication carelessly. Only when the distress of the child and the family has become unbearable and all other measures have been exhausted are they used. This is when the family and school conditions have been optimised, but the support and therapies are not sufficient to ensure that those affected are comfortable in their environment and can make progress in their development. The drugs cannot heal, but they create capacities that can be used to acquire the necessary strategies for dealing well with the handicap (Heidelberger, 2016, p. 42)

The claim in this statement that stimulants are prescribed only carefully seems to be rather romantic and ignores recent critiques of prescription practices, such as the over-medicalisation of immaturity in the youngest children of a school class (Armstrong, 2006) and the concern about using medication for human enhancement (Haubl and Liebsch, 2010b). The main decisive factor in evaluation processes regarding medical interventions is described here as being the distress, both in the family and the child.

It is remarkable that, as a teacher, the author of this statement does not include the school and particularly teachers and classmates in her account. Arguably, the perceived burden a child termed 'ADHD' puts on a class, and particularly teachers, often leads to some sort of pressure on the part of the school to get a child assessed and drugged. Moreover, according to this statement, stimulants are only used if 'all other measures have been exhausted' and 'the family and school conditions have been optimised'. This again seems to be a somewhat romantic view. It is highly unlikely that the

main determinants of the distress caused in children labelled with 'ADHD' are being removed through what the author refers to as 'optimisation'. Rather, children tend to become subjected to a number of measures, including the introduction of 'more structure' in the classroom alongside individualised therapeutic interventions. In their report on a study conducted in Zurich, Rüesch et al. (2014) argue that the school is the primary environment where children labelled with 'ADHD' experience problems, which in turn leads to significant distress in children and their parents. They identified some critical areas, which include 'homework (scope), time management in class (especially in examinations) and learning objectives' (ibid., p.72). However, I will elaborate in more detail upon the role of the school (and other social spaces) in the context of 'ADHD' throughout the next chapter.

The reference to the idea that stimulants 'cannot heal' (see statement above, Heidelberger, 2016) reflects the idea that there is no cure for ADHD and that treatment is only aimed at mitigating symptoms. Arguably, what is being managed here is the child who displays 'deviant behaviour', both in terms of too much activity (usually referred to as hyperactivity) or not enough activity (usually referred to as daydreaming). Arguably, the distress (both of the individual themselves, and their environment) plays a key role in decisions regarding pharmacological treatments for children. As a key decisive factor, the distress may also serve to legitimise drugging practices in the absence of a clear diagnosis. As a psychologist argues in an article published by Elpos,

[o]f course, ADHD-specific treatment can also be carried out in cases of high levels of distress even if there is no confirmed ADHD. In the case of complex disorders, it is quite possible that, despite careful examination, it may not be possible to conclusively determine which diagnosis has therapeutic priority. If a patient responds to treatment with a stimulant, the ADHD diagnosis is indirectly confirmed (without, however, stating anything about possible therapy-relevant concomitant disorders). On the other hand, the reverse conclusion that non-response to stimulants excludes ADHD is not permissible. Reason: Not all ADHD patients respond to treatment with stimulants (Rossi, 2016a, p. 17)

Hence, high levels of distress serve to legitimise medical treatment of children even in the absence of a clear diagnosis. While the diagnosis of

'ADHD' has been criticised for being unspecific (Abraham, 2010), highly subjective (Barnes et al., 2003) and describing normal childhood behaviour (Conrad and Schneider, 1980), drugging children in the absence of such a diagnosis seems to be even more problematic. Furthermore, the claim that 'if a patient responds to treatment with a stimulant, the ADHD diagnosis is indirectly confirmed' represents an 'ex-juvantibus' reasoning (Hasler, 2013; Leuzinger-Bohleber et al., 2006; Schmidt, 2019). This reasoning construes an inference about a disease entity from an observed response to a treatment. According to this logic, the effect of stimulants, particularly the reduction in physical activity and the increase in sustained attention, is considered a paradoxical effect, and therefore a sign of 'ADHD' in a particular child. 'Normal' children, so the argument contends, would not calm down under the influence of stimulants. However, these 'convoluted arguments' (Rose, 2005, p. 258) have been refuted. Nevertheless, they still serve to legitimise medical intervention, even in the absence of a diagnosis.

The 'distress', though, does not necessarily (or even primarily) refer to an individual. Arguably, the interests of the environment, particularly the school (Rüesch et al., 2014) and the family (Cooper and O'Regan, 2002) are important in making decisions about drugging children. In her extensive account of the new DSM-5 (APA, 2013), a journalist elaborates on the tendency to widen psychiatric diagnoses and to turn social problems into medical ones. In a provocative way she argues that

[i]f being ill means distress to oneself, then being ill in children is the distress of others. Parents ask teachers, teachers ask school psychologists: The child robs me of my last nerve, must [they] be treated? Or [do they] just need special support? (Schmid, 2013)

The article goes on to problematise that some behaviours in children, for example extensive tantrums, may be medicalised just because they are annoying. An indicator that children are potentially treated because of their annoying behaviour may be the tendency to diagnose and treat children at an ever-younger age. The new *German Guideline on ADHD* (DGKJP et al., 2018a) suggests starting treatment at three years of age, while the previous

edition suggested starting treatment at age six. These practices are also entangled with the shift in discursive practices towards early intervention and optimisation (Wastell and White, 2017). I will, however, elaborate on these practices in the next chapter.

Moreover, macro-level environmental shifts, such as increases in (both) parent's employment, may affect child-parent relationships and the decision to medicalise children. In an article entitled 'Parents sedate babies with medication' (Zanni, 2016), a journalist elaborates on how the behaviour of infants may lead to stress in parents:

[n]either consolation nor the dummy helps: The baby screams through half the night. This brings some parents to the brink of despair. 'There are those who suffer so much from crying babies that they administer drugs to treat itching, such as Fenistil drops,' says [the interviewee], head of the Stadelhofen family practice in Zurich. She even knows of a couple who have been prescribed Ritalin by a doctor for their toddler (ibid.).

Medication, thus, is used as a means to render children, and even infants, more docile. It becomes part of regimes of practices that aim to produce certain behaviours (cf. Comstock, 2011).

## Summary

This section has elaborated upon the role of distress in children in the context of the discourse around ADHD. This includes re-conceptualising the child as being unable to conform to the rules (and thus being 'ill'), rather than unwilling (and therefore being 'bad'). However, such discursive practices do not necessarily empower children whose behaviour has been problematised. Rather, they potentially become subjected to pharmaceutical treatment in the presence (and even in the absence) of vague diagnoses. Distress, in this context, has become a main decisive element. This may be interpreted against the definition of mental illness that I discussed in the literature review (cf. **Diagnostic Criteria**, p.20). In the absence of a demonstrable underlying physical pathology, the 'level of subjective distress' (Katona et al., 2015, p. 7) is being used to determine whether a particular person is considered to have a mental illness or disorder. This level must be 'greater in severity or duration

than occurs in normal human experience' (ibid., p.7), which is determined through thresholds that are set out in diagnostic manuals (see APA, 2013; World Health Organisation, 2019). It is against this backdrop that distress not only serves to substantiate the discursive shift in the conceptualisation of children from 'bad' to 'ill' but also to legitimise medical intervention in the absence of any demonstrable physical pathology.

The subjectification to pharmaceutical agents that are considered the gold standard of medical intervention, though, arguably aims to normalise the behaviour displayed in children. Such normalised behavioural patterns are considered a core feature of what may be termed the Athenian image of childhood, which emphasises the role of self-governance in performing advanced liberal subjectivity. It is to this emphasis on self-governance that the exploration now turns.

## **Representations of Self-Governance**

Building on the ideas regarding idealised images of childhood as discussed so far, this final section elaborates on the notion of 'good behaviour', then explores the claim that therapy leads to 'becoming one's true self'. The final part considers possible links between 'creativity' and 'ADHD'.

### **Defining Good Behaviour**

The following image shows a child sitting at a table, writing on the back page of a worksheet:



Figure 13: "Nine-year-old Kilian suffers severely from the symptoms of ADHD and takes a high dose of a Ritalin-like drug. The pressure of school puts him under a lot of strain. His deepest wish: 'To be able to write more beautifully'" (Jeitziner, 2005)

The background of the image looks like a private home rather than a school environment; hence it may be argued that the boy is doing homework. Sitting there and focusing solely on the task as instructed reflects the type of behaviour expected from an advanced liberal subject who invests in their own future. Since the boy, as described in the caption of the image, has 'severe symptoms', he takes a 'high dose of a Ritalin-like drug' in order to perform according to the expectations of the school. While the medicalisation of the child has led to (more) docile behaviour, handwriting seems to be a challenge for the boy. The way he holds the pencil suggests that he uses too much force and the handwriting does not seem to meet expected standards. In contemporary education being able to write is not enough. In order to be successful at school the handwriting must be beautiful. As 'pressure of school puts him under a lot of strain', the boy invests a lot of effort into expectations, hence his 'deepest wish' is to write more beautifully.

As mentioned in the section Representations of Deviance earlier in this chapter, ADHD is defined as a behavioural disorder (APA, 2013). Hence there is a strong emphasis on what 'deviant' behaviour looks like. In contrast to these problematised behavioural patterns, the value of self-governance in the light of an idealised Athenian image of childhood is being emphasised in the hegemonic discourse. It is in this context that the concept of 'executive functions' (cf. Barkley, 1997) is being emphasised. In her account, published by Elpos, a psychologist argues that

ADHD has been regarded as a problem of executive functions for several years (Barkley, 2007), i.e. those affected have difficulties in planning, monitoring and completing tasks well. Among the most important executive functions are self-control, attention, motivation (Brunsting, 2016a, p. 22)

In another article (also published by Elpos), the same author expands on the importance of executive functions. She argues that these functions encompass the following:

1. Action planning (How do I proceed? What do I start with?)
2. Organisation of the behaviour (I will now learn for the announced exam. Now I put my material ready for it and clear away everything superfluous.)
3. Time management, sense of time (how long do I think it will take me to complete this task? Am I within the schedule?)
4. Flexibility of the behaviour (the last examination did not go so well at all. What about my behaviour do I change for the next one?)
5. Working memory (Do I still know which tasks are due or should I look in the agenda/weekly schedule?)
6. Self-regulation a) Attention: How attentive am I now? b) Affect: Am I motivated or do I have to 'conjure the motivation out of the hat', for example with a reward?  
c) Impulse: Can I calm down again when I have the impulse to throw everything away?
7. Metacognitions (What have I done? What did I learn? Where can I use what I have learned?)
8. Control, correction and reflection (Now I read everything word for word or letter for letter and check if everything is correct. If something is wrong, I correct it carefully.)  
(Brunsting, 2016b, p. 21)

The elaboration of these eight items of the 'map of executive functions' (ibid.) thus describes the idealised notion of an advanced liberal, self-governing child. Arguably, behaviour is here primarily understood in terms of the



requirements of the specific settings that mass schooling approaches have produced. Consequently, a child is not simply expected to achieve good grades. Rather, they should plan every step of the learning process well, should organise the learning environment and manage the time needed for each task.

Particular emphasis, however, is put on 'self-regulation'. Hence, children should not only be attentive but also reflect on their ability to be so. This includes the reflection on one's own motivation. Is the motivation simply naturally there to perform the next task, or has it to be produced 'magically'? The reference, though, to triggering motivation through a 'reward' seems to be a rhetorical question. It may be argued here that those children labelled with 'ADHD' will hardly identify a way to 'reward' themselves within the context of school settings, as these very settings are arguably a main contributing factor in the causation of their difficulties. The further reference to 'impulse' concerns what is often referred to as 'hyperactivity' in children labelled with 'ADHD'. Yet a self-governing child will manage to regulate his or her impulses and stay calm and focused. While it may be argued that such behavioural patterns are indeed preferable in particular contexts and settings, they may well stand in contrast to the needs of (particularly younger) children. Additionally, they potentially narrow down the idea of 'normal development' in that they provide a basis for the pathologisation of behaviours that deviate from such idealised standards.

While self-regulation is a core feature of the concept of advanced liberal subjectivity (cf. Dean, 2010; Rose, 1999), the importance of reflexivity is arguably as much emphasised (Smith, 2012). Against this backdrop the term 'metacognition' refers to the ability to reflect on both awareness and understanding of one's own thought processes. Particularly the last question 'Where can I use what I have learned?', however, seems to be somewhat sarcastic in the light of standardised schooling. Critical educators have repeatedly pointed to the necessity of making education more meaningful to children (see, for example, Czerny, 2010; Robischon, 2019). Particularly the

approach of cutting down the learning processes into very small steps and standardising these steps in terms of spatiality and temporality seems to potentially strip contemporary educational practices from meaning. Yet, as a psychologist suggests in an article published by Elpos,

[o]ne of the main goals of any ADHD therapy is the ability to dedicate oneself to something that is not so interesting subjectively. If a child with ADHD has a reasonably good command of this, [they] can listen to a teacher even if it sounds less interesting, can stick to [their] homework, even if [they] do not see any sense in it personally, or follow the mother's request even if it is a subjectively unpleasant task, such as bundling waste paper (Rossi, 2016b, p. 50)

In other words, children are subjected to a learning environment that may be boring and completely void of any meaning to them. If they, though, react in undesirable ways to this loss of meaning in their learning process, then this becomes pathologised. The main aim of 'ADHD' therapy, therefore, seems to be to adapt children to the void. Thus, contemporary discursive practices seek to foster such subjectivity and the unfolding of the 'true self' in children through therapeutic interventions. It is to these practices that the elaboration now turns to.

## **Becoming One's True Self**

As I have argued earlier in this chapter, there is a certain idealised subjectivity that contemporary discourses on childhood in the minority world (and, arguably, beyond) seek to foster. The assumption that children who are of 'normal' intelligence but do not behave in schools according to standardised expectations are affected by some form of pathology again contributes to the move away from Dionysian towards Athenian conceptualisations of childhood. Against this backdrop the assessment of children's intellectual abilities plays a pivotal role. In a media article a journalist describes the journey of a child

from test to test, from expert to expert, because the parents only want the best for their child and have [them] comprehensively examined. There is little support from the teacher; she considers the girl with an IQ of 138 to be lazy. At some point the diagnosis is ADD, the attention deficit syndrome without hyperactivity. Further tests are to follow. And above all: therapies (Rau, 2013)

While the child is ‘comprehensively examined’, it is arguably their IQ that is most important in the identification of the gap between what is often referred to the ‘potential’ of the child (see also the next quote further down) and the performance demonstrated in the school. This is an impressive example of the power that a single number (cf. Rose, 2004), here in the form of the ‘intelligent quotient’ (IQ), bears. The current ‘thought style’ holds that the whole complexity of childhood experience and behaviour can be reduced to a (rather simplistic) numeric value and then put it into a relationship with the performance demonstrated at school. In the example described above this led to the diagnosis of ‘ADD’, again emphasising ‘illness’ rather than ‘badness’ in the form of laziness, as proposed by the teacher.

In the light of a gap between scholastic performance and assessed IQ, the child is then subjected to therapeutic measures that aim to enable the child to fully use their ‘potential’. As mentioned by a psychologist in an article published by Elpos,

[i]t is certainly desirable and pleasant if disturbing behaviour and poor concentration can be reduced during treatment. It is even much more important, however, that a child can develop according to [their] potential and be the way, respectively can become the way [they] truly [are] thanks to therapy (Rossi, 2016a, p. 14)

The underlying assumption here, hence, is that there is a ‘true self’ that has yet to be unfolded through therapy. This resonates with Carl Rogers’ work *On Becoming a Person*, in which he offers some contemplations on ‘To Be The Self One Truly Is’ (Rogers, 1970, p. 163ff). Rogers particularly elaborates on the question of ‘what is the goal, the purpose, of my life?’ (ibid. p.180). Arguably, in the light of the current discourse, the purpose of life is to become an advanced liberal, prudent and productive citizen who acts only after carefully considering all relevant risks. When Carl Rogers wrote this in 1961 psychotherapy was considered the first choice in addressing ‘deviant behaviour’ and in channelling conduct into certain patterns. However, more recently, pharmaceuticals, and particularly stimulants, are believed to be the

best way to treat children labelled with 'ADHD'. The same psychologist as cited above argues, in another article published by Elpos, that

[m]ost ADHD affected people succeed (regardless of age) only under the therapeutic effect of stimulants to think about themselves, their feelings and their behaviour in peace. Self-reflection, a basic competence necessary for any psychotherapy, is often only made possible by the use of stimulants in ADHD affected persons. People treated with medication feel more easily what they really want and what they do not want. They act consistently and are less likely to be dissuaded from the course by quick but often lazy compromises (Rossi, 2016b, p. 50)

In a similar vein to Carl Rogers (1970), the author of this quote argues from the perspective of the psychotherapist. According to this more recent approach, however, psychotherapy is believed to be successful only with the support of the 'therapeutic effect of stimulants'. Yet, this is a much-disputed point. For instance, Swiss pharmacologist Amrei Wittwer (2019), who co-lead the project Promoting the Development of Children: An Interdisciplinary Study on Dealing with ADHD (cf. Rüesch et al., 2017), argues that stimulants have no therapeutic effect at all. While there is a dispute around the therapeutic aspect, though, that does not mean that these pharmaceuticals have no effect at all. Sybille Rockstroh (2002), a Swiss psychologist, argues that while stimulants do have some desirable effects, including the prevention or temporary suppression of fatigue, they do not offer a 'cure'. Furthermore, the effects of stimulants may be observed in the general human population, rather than only in those labelled with 'ADHD' (ibid.).

Describing 'self-reflection' as a basic competence in shaping oneself towards desired ends, 'regardless of age', seems to be yet another reference to the idealised notion of the Athenian child that contemporary discourses aim to foster in children. Moreover, the claim that children on stimulants 'feel more easily what they really want' collides with ethical considerations. The Swiss National Advisory Commission on Biomedical Ethics (NEK-CNE, 2011) problematised, in its *Opinion No. 18/2011: Human enhancement by means of pharmacological agents*, the use of stimulants in children. The central argument is

that the distinction between enhancement and a need for therapy can vary depending on the cultural and historical context – and as a result is subject to ethical reflection (ibid., p.5)

This thesis regarding cultural and historical dependency of prescription rates receives support in the critical literature (see, for example, Haubl and Liebsch, 2010b; Timimi, 2009a). As discussed in the section Representations of Deviance earlier in this chapter, statistical data on prescription practices across cultural settings in Switzerland (and indeed beyond; see, for example, Conrad and Bergey, 2014) seem to further substantiate such lines of argument. In addition, the massive increase in prescriptions for methylphenidate took place in the last two decades only, even though the pills have been available since 1955 (NEK-CNE, 2011).

Against this backdrop, prescribing stimulants to children may potentially be regarded as enhancement, ‘alter[ing] the child’s behaviour without any contribution on his or her part’ (ibid., p.4). The NEK-CNE argues that drugging a child for the purpose of enhancement

amounts to interference in the child’s freedom and personal rights. Because pharmacological agents *induce* behavioural changes but fail to educate the child on how to achieve these behavioural changes *independently*, the child is deprived of an essential learning experience to act autonomously, namely to influence his or her behaviour through personal decisions rather than external means (alone), which would allow the child to take responsibility. Within this context, enhancement considerably curtails children’s freedom and impairs their personality development (2011, p. 5, emphasis in original)

From this point of view, the child should be empowered to act as an autonomous person through relevant learning processes. There is a clear focus on agency in this statement, framed by a children’s rights perspective. Article 12 of the United Nations Convention on the Rights of the Child (Committee on the Rights of the Child, 2009b) explicitly advocates for the participation of children in all matters affecting them, but the interpretation of the ‘best interest of the child’ is made by adults (Kerber-Ganse, 2009). This interpretation is often a paternalistic one in which the views and perceptions of adults regarding the behaviour displayed in children serve to legitimise the drugging of children (Amft et al., 2004).

While the hegemonic discourse argues that medication primarily addresses distress in children and is in their best interest, children themselves see medication more critically (see, for example, Cooper and O'Regan, 2002; Haubl and Liebsch, 2010a). As has been discussed in the literature review (cf. **The Voice of Children**, p.66), however, children's own accounts are rather marginalised in debates around the rights of children in general, and about medicalisation in the context of 'ADHD' in particular. The absence of children in the debate around ADHD is also striking in the discourse on childhood ADHD in Switzerland. While there are rare references to the views of children in the 1139 media articles analysed as part of this thesis, only three articles include statements from children themselves. The longest amongst these has been published as a letter to the editor by a 10-year-old boy in response to an article that problematised the use of pharmaceuticals in the context of behavioural disorders in children. Whether this response is authentic, i.e. truly written by a 10-year-old boy, is, though, not possible to determine. The letter reads

[m]y name is Mäx, I'm 10 years old and I've been taking Ritalin for a year, fortunately... Because if I don't take Ritalin, I have a lot of quarrels with my mother, teachers and my siblings. I then simply do what I want and can no longer obey (but I actually want to)... Thanks to Ritalin, I have it much easier with myself and my environment. I am now in a private school, and life is great again (Känzig, 2002)

This account echoes the first type of typology of positive representants of the medication in boys as proposed by Haubl and Liebsch (2010b, p. 204ff) which I briefly introduced in the literature review (cf. **The Voice of Children**, p.66). Haubl and Liebsch suggest that boys who fall into this type of representant perceive pharmaceutical agents primarily as a means of 'social pacification', since relationships with significant people are being improved. Mäx's account, by listing his mother first amongst those affected by 'quarrels' if he does not take the drugs, seems to support the argument of Haubl and Liebsch that the improvement in relationships with 'significant others' concerns foremost mothers. They further argue that the improved

relationships, which are ascribed to psychotropic drugs, may take place even if the boys do not recognise any difference in their behaviour (ibid.).

However, the account of Mäx suggests that he is aware of the change in his behavioural patterns. In the absence of medication, he argues, he would just ‘simply do what [he] want[s] and can no longer obey (but [he] actually want[s] to)’. Interestingly, there are two references here to what Mäx wants. First of all, without medication he ‘does simply what he wants’, which excludes the ability to ‘obey’. Second, however, he ‘actually wants to obey’. This brief account thus supports the claim that medication helps children to ‘feel more easily what they *really* want’ (see full quote further up in this section, Rossi, 2016b, p. 50, emphasis added). In other words, medication is here depicted as a means of becoming one’s true self and performing according to expectations against an Athenian image of childhood. It is to this aspect of performing what may be termed advanced liberal subjectivity that the discussion now attends.

## **Performing Advanced Liberal Subjectivity**

This elaboration of how advanced liberal subjectivity is conceptualised is organised along three aspects, i.e. claims to the significance of drugs in living a more ‘normal’ life; reflexive thinking and creativity; and the alignment of conduct with scholastic requirements. Let us first consider the claimed role of drugs.

### **The Role of Drugs in Living a More Normal Life**

As discussed earlier in this chapter, ‘ADHD’ and the technologies that come with it seek to subject children who display ‘deviant behaviour’ to a regime of practice (Dean, 2010) that renders them into self-governing subjects (Smith, 2012). Since the contemporary hegemonic discourse emphasises the value of medicalisation in these practices, outcomes of ‘therapeutic’ interventions are generally described in relation to medication. In a newspaper article a psychologist and ‘key opinion leader’ of international format, who

understands ADHD as purely biological and in need of medical intervention, argues that

Ritalin acts in the brain regions where the executive functions are located and influences the dopamine metabolism in the synapses. It helps patients and their families living a more normal life, be more successful, be less punished and even live longer. On average, people with ADHD die earlier than others because they take more risks. That is why treatment is not only good, but also very important (Meili, 2008)

The ultimate aim of pharmaceutical intervention, hence, is to enable recipients to live a 'productive life'. The claim that 'treatment is not only good but also very important' contains a moral message. Therefore, medicating children is the 'right' choice. However, as mentioned in the previous section, the practice of drugging children in the context of 'ADHD' has been problematised from an ethical point of view, namely regarding historical and cultural variance. In the interview cited above the psychologist further argues that 'over 7000 studies have clearly shown that ADHD has only biological causes' in order to legitimise the use of pharmaceuticals. While this statement clearly represents the current 'thought style' (Fleck, 1979) by presenting the causal basis of 'ADHD' as a 'scientific fact', the link between biological reductionism and pharmaceutical intervention is not simply self-explanatory. As I have illustrated in the previous chapter (cf. **Etiology and Genetics**, p.130), only through a complex process that Fleck termed a 'sociocognitive migration of fragments' are knowledges put together and altered in order to produce 'impersonal vademecum [sic] science' (ibid., p.118). The outcome is a 'scientific fact' that is based on mutual agreement and freed from contradictions and incongruencies.

The reference to 'living a more normal life, be more successful, be less punished and even live longer' serves to construct images of normality and subjectivity. As Rose argues, these images are presented in a way anyone 'would have to be sick or pathological to reject' (Rose, 1999, p. 251). In support of these 'transcendent images' (ibid.), the discourse on ADHD consequently highlights stories of positive outcomes of (medical) treatment



with reference to the idealised notion of an advanced liberal subjectivity. In a letter to the editor a teacher argues that

[a] total of nine of my students were treated with Ritalin and were continuously cared for by the doctors. These children could never have been integrated into a normal class over a longer period of time. A meaningful teaching would have been simply impossible. A boy jumped on his classmates from behind and bit them in the neck. With Ritalin he didn't harass anyone, he could follow the lessons. He completed his technical college {Technikum}, is happily married and a proud father (Daum, 2005)

In order to make this a strong story the author uses a rather extreme example of 'deviant behaviour', which is then rendered into 'normal behaviour' through pharmaceutical agents. The aimed for outcome of behaving 'normal', i.e. 'following the lessons' is described as the successful completion of both secondary school and tertiary education at the technical college. Graduating from a technical college in Switzerland leads to a rather prestigious title of either 'architect' or 'engineer'. The reference to this degree thus aims to make the statement strong. The story completes with the reference to happy marriage and proud fatherhood, which is reminiscent of how many fairy tales end: 'and they lived happily ever after'.

### **Reflexive Thinking and Creativity**

In a similar vein, a paediatrician reports, in an article published by Elpos, on how educators tend to highlight the benefits of the medication he is prescribing. He cites a teacher to support his argument:

[f]inally, my student has been treated with medication for several months now. We teachers clearly notice that this can help her: a confused, unfocused student becomes a thinking person who can express herself, it is wonderful to experience! (Ryffel, 2016b, p. 18)

'Normal behaviour', consequently, excludes being confused or unfocused at times. The medication, this quoted teacher argues, turns the student into a 'thinking person' and allows her to 'express herself'. This is a rather binary view: thinking either takes place or it is absent. References to the importance of 'thinking' in performing advanced liberal subjectivity can be found throughout the discourse around ADHD. In an article published by Elpos a

psychologist elaborates on the idea of 'divergent thinking' as a necessity to show flexibility in solving problems. He claims that

[u]nder the influence of stimulants, many ADHD affected children show a more creative, spontaneous and flexible problem-solving behaviour in addition to better self-control and more resistance to distractions. This refers to the ability to generate as many different approaches to solving problems as possible (so-called divergent thinking). The following problem is an example: Björn gets stuck while solving his homework. He sees no solution, reacts frustrated, gets annoyed with the math book and grabs his mobile phone to look for new Facebook entries. Ideally, Björn would more or less patiently look for different solution possibilities when he gets stuck instead of reaching frustrated for his mobile phone. The probability that he could find a solution to the math problem appropriate to his intelligence would clearly be higher. Also Björn would appear to outsiders much more patiently (Rossi, 2016b, p. 49)

This statement is of interest as it brings self-control, resistance to distractions and creativity in problem-solving behaviour into a relationship. The author argues that under stimulants many children develop 'a more creative, spontaneous and flexible problem-solving behaviour' in addition to the other two characteristics. This suggests that subjecting the body to medical interventions to render it docile increases the creativity, spontaneity and flexibility of children when solving scholarly problems. This seems to be a rather bold statement, though. While there is no universal acceptance of a definition or assessment of creativity, Getzels and Csikszentmihalyi (2017) propose that it involves unconventional thinking of great intensity and reflections on the problem itself. They argue that a concept of creativity should not only focus on problem-solving but also include the dimension of problem-finding to yield novel perspectives. In a similar vein, Boot et al. suggest that the behavioural patterns problematised in children labelled with 'ADHD' are 'associated with enhanced divergent thinking and with a more original, but less practical, reconstruction of complex problems' (2017, p. 73).

In addition, Cramond (1994) has compared children labelled with 'ADHD' and 'high creativity' based on assessments using both DSM-IV (APA, 1994) and Torrance Tests of Creative Thinking (1992). She suggests that these two 'syndromes' have a high similarity, which may potentially lead to misdiagnosis of 'ADHD' in highly creative children. Their 'disturbing

behaviour' in classrooms, including talking during tasks, daydreaming, impulsiveness, and high tolerance for ambiguity, she suggests, may be interpreted as maladaptive, even though they constitute essential components of 'creativity'.

In a similar vein, Shaw (1992) argues that children labelled with 'ADHD' tend to show a high level of creativity. The traits he identified that discriminate these children from a control group include the ability to perceive coherence tacitly, to use imagery in problem solving and to use incidentally acquired information. Furthermore, these children show left-sided laterality and tend to experience difficulties with verbal learning. Shaw argues that a number of studies have demonstrated interconnections between laterality and 'deviant behaviour', including impulsivity. Shaw suggests that boredom, which is likely to be produced in such children in the context of contemporary mass education, is aversively stressful in creative people, and unbidden thoughts are common (*ibid.*).

In the light of this body of critical literature, it seems highly questionable whether subjecting children labelled with 'ADHD' to psychotropic drugs, as suggested by the psychologist in the statement above (Rossi, 2016b, p. 49), leads to 'more creative, spontaneous and flexible problem-solving behaviour'. While signs of 'better self-control and more resistance to distractions' (*ibid.*) may be observed in many of these children, it is doubtful whether their 'creativity' in problem-solving is really increased through such measures.

The author of that statement problematises the way the boy moves away from the maths textbook rather than to 'more or less patiently look for different solution possibilities' when he gets stuck with homework. However, drawing from the perspectives briefly introduced above, it may well be argued here that exposing a child with a high level of 'creativity' to a boring task, such as a maths problem in a standardised textbook, is aversively stressful. Rather than subjecting such children to a medical regime it might further be argued that offering a learning environment that actually is interesting and meaningful to highly 'creative' children would achieve higher levels of arousal

and facilitate the cognitive processes that they favour most. Although stimulants do channel attentional capacity and perseverance in children during boring, monotonous tasks, they tend to reduce flexibility, curiosity and incidental learning rather than increase them (Shaw, 1992).

### **Aligning Conduct with Scholastic Requirements**

Nevertheless, the hegemonic discourse primarily emphasises the usefulness of stimulants as a means of aligning conduct with scholastic requirements. It is against this rationale that the outcomes of pharmaceutical interventions are generally described. In an article published by Elpos a psychologist elaborates on 'psychological aspects of stimulant treatment'. In this short account he highlights 'what teachers should know about medication':

[p]ositive changes that you can notice: The child can listen to explanations and follow rules. Tasks are more likely to be started and finished. [They have] improved motor skills, [are] less fidgety or 'more awake'. The handwriting improves, the concentration span is longer. [They have their] impulsiveness better under control (Stucki, 2016, p. 29)

This reads like a checklist for teachers to assess the level of 'self-governance' performed by their students. The focus here is clearly aligned with the requirements of contemporary mass schooling. Children who are rather active and labelled 'fidgety' are expected to calm down, while those caught daydreaming are expected to become 'more awake' under the treatment of stimulants. Behavioural patterns are thus channelled, normalised and opened for assessment. Such standardised conceptions of behaviour patterns, and more generally the requirements imposed on children by contemporary mass schooling, are also extended into the home through the technique of homework. In a media article a journalist reports on the lives of ten-year-old Max and eight-year-old Tobias, both subjected to pharmaceutical treatment:

[u]nlike Max, Tobias still knows exactly what it's like not to take Ritalin. When asked what's different today, he says like a shot: 'I'm faster with the homework'. Before that, he had struggled with tasks that he would have been able to solve without any problems, says his mother: 'But he simply didn't put the solution on paper' (Minor, 2007)

For Tobias, then, being faster with homework tasks seems to be the most important change that stimulant treatment has brought about. This echoes the third type of positive representants of pharmaceutical agents, as proposed by Haubl and Liebsch (2010b), that emphasise increased scholarly performance in medicated children. The reference of his mother to the issue that Tobias 'struggled with tasks that he would have been able to solve without any problems' reinforces the idea of matching behaviour displayed in children with their intellectual abilities, as discussed earlier in this chapter.

While there are frequent references to appropriateness of educational outcomes in relation to 'intelligence', no reference is made to other characteristics, such as laterality, personality or trait, in the dominant discourse. All the effort, it seems, is put on subjecting children to normalising processes and promoting a 'gold standard' of the Athenian child. As a result the body of children labelled with 'ADHD' is potentially rendered docile and the level of creativity 'normalised' rather than increased.

## **Summary**

This final section of the chapter regarding constructions of childhood has elaborated upon representations of what it means to perform advanced liberal subjectivity. I have argued that the usefulness of drugs is linked to processes that aim to normalise the conduct of children and that emphasise how such normalisation will lead to a 'better life'. The exploration then turned to critically examine the claim that pharmaceutical interventions may increase reflexive thinking and creativity. Although stimulants may channel attention capacity, they also tend to reduce flexibility, curiosity and incidental learning in children. Finally, I have suggested that the idea of self-governance is aligned with scholastic requirements, both at school and, through homework, in the private home.

## **Conclusion**

This chapter has examined the visual representations of children labelled with ADHD along three emerging themes of deviance, distress and self-

regulation. I have argued that these themes serve both to contrast with and support the Athenian conceptualisation of childhood as proposed by Smith (2012). This image represents an advanced liberal subjectivity, emphasising agency and participation but also responsibility and reflexivity. The following sections briefly summarise the main findings.

The findings illustrate that deviance in children is regarded as a sign of significant troubles to come. For example, having a tantrum is rendered pathological and opened up for medical intervention. However, it is not the single tantrum that renders a child pathological. Rather, contemporary psychiatric manuals such as the DSM have come to establish a threshold that indicates pathology. For example, the invention of Disruptive Mood Dysregulation Disorder, as proposed by the new DSM-5, suggests that this threshold is reached by a child having three tantrums per week. The results further indicate how such definitions are political rather than scientific and are linked to power/knowledge relations that were elaborated upon in the previous chapter.

In a similar vein, the foundation of 'ADHD' as a 'behavioural disorder' lies in the description of deviant behaviours, which in turn serves to identify those children who display them. Apart from tantrums that are problematised as 'impulsivity' within the understanding of ADHD, a plethora of further behaviours are problematised. A particular focus lies on the physical activity level of children (where derivations from a 'norm' are considered as either 'hyperactivity' or 'daydreaming'), and on their inability to align their attention span with scholastic demands.

Accordingly, to emphasise the nature of ADHD as 'illness' the discourse establishes the idea of pathology in certain behaviours. An important means of doing so is by labelling behaviour displayed in children, or even children themselves. For example, children are described as being 'unbearable', 'disruptive', 'disobedient' and 'aggressive'. In some instances nouns are used to relate to children themselves rather than to their behaviour, for example by describing a child as being a 'monster'. Such labels are reminiscent of the

discourses of the 'evil child' as represented by the Dionysian image of childhood (cf. Jenks, 2005). However, through pathologisation the child is rendered ill as opposed to evil, which reflects more recent conceptualisations as encompassed in the image of the Apollonian (and, more recently, Athenian) child. Against this backdrop the child does not need to be beaten into submission but is in need of therapeutic interventions.

The labelling process hence serves as legitimisation for subjecting children to a range of therapeutic, sovereign and disciplinary measures, including the prescription of psychotropic drugs. An important part of this legitimisation, though, is the reference to the future. Although the present behaviour is problematised, the real concern lies with the future outcome for the child, i.e. whether they will become an asset or a liability from a societal point of view (cf. Smith, 2012). Discursive practices therefore employ a range of strategies and technologies concerned with the identification and management of risk.

The idealised prudential subject of advanced liberal societies, represented by the Athenian image of childhood, is expected to govern themselves and to calculate both the benefits and costs of acting in a particular way. Consequently, deviant behaviour is considered risky, unhealthy and immoral. Children labelled with 'ADHD' thus challenge the very notion of what it means to be a child and attract particularly strong interventions.

Another important aspect of contemporary discourses around children and ADHD is the focus on the distress the 'illness' of ADHD brings. Images presenting the child trying hard to focus but being unable to do so aim to substantiate the idea of the child being 'ill' rather than 'bad'. Moreover, such a (visual) rhetoric serves to legitimise the prescription of psychotropic drugs to ever younger children, since they aim to alleviate distress arising from their inability to conform to the (scholastic) requirements imposed on them. An important message conveyed here is that children are not unwilling but unable to suppress their impulses and sustain their attention, particularly in the setting of the school. Such arguments are built by referring to research claiming that children 'do not know what they are doing', since they are being

determined in their behaviour by processes in their brains. Such references emphasise the inability of such children to suppress their impulses.

The claim that these children are ill is then further substantiated by referring to the wider consequences of ADHD, such as school dropout and the inability of these children to build and maintain friendships. Here the normalising processes of discourses become highly visible. For example, the behaviour in children is being problematised not only if they are too outgoing but also if they are not outgoing enough. In both cases they are rendered problematic and subjected to therapeutic interventions. Hence, these 'regimes of practice' around ADHD aim to substantiate the claim that children are not bad, but rather suffer from a condition that determines their behaviour.

The findings also highlight that there is a more recent shift in discourses around ADHD that may at least partially replace biological determinism with the idea of plasticity. This reflects the idea of malleability and perfectibility, which are shared elements of the images of childhood as proposed by Jenks (2005, 1996) and further developed by Smith (2012). The results further illuminate how the distress in children labelled with 'ADHD' is used as a means of legitimising psychotropic interventions. Accounts of parents of medicated children are used to substantiate such claims. For example, a mother describes the drugs as a 'blessing' and an ordinary life without them as 'unthinkable' (Minor, 2007).

The findings illustrate how the idea of 'distress' is being used as a main decisive element regarding diagnosis and, particularly, medical treatment. By presenting 'vivid examples' (Best, 2001) of the distressed child the discourse aims to raise concern regarding children labelled with ADHD. These examples are not typical but rather 'especially dramatic' (ibid.). However, throughout the hegemonic discourse, activists promote them as representative of ADHD.

By focusing on distress rather than deviant behaviour such pictorial representations aim to describe children in terms of the burden that the



illness of ADHD puts on them and aim to foster pity rather than anger in the beholder. The idea of the ill, distressed child lays the ground for medical intervention, legitimised by the moral obligation to alleviate distress. However, presenting such prescription practices as justified and careful obscures more problematic aspects, such as the potential over-medicalisation of immaturity (cf. Armstrong, 2006) or the use of medication as human enhancement (cf. Haubl and Liebsch, 2010b).

The results illustrate that distress, not only in children themselves but also in those people around them, has become a main decisive factor in evaluation processes regarding medical interventions. As a consequence, high levels of distress may serve to legitimise medical treatment of children even in the absence of a diagnosis.

Additionally, this exploration has brought to the fore a certain focus on what might be called the Athenian image of childhood. This is most visible in the emphasis on the so-called 'executive functions', which promotes the idea of the self-governing subject of advanced liberal rule (Dean, 2010; Rose, 1999; Smith, 2012). These functions include a wider range of behavioural ideals, such as self-regulation, flexibility, time management and reflection (Brunsting, 2016b, p. 21).

The findings illustrate how such idealised behavioural patterns are tightly enmeshed with the requirements and objectives of contemporary schooling. Against the idea of a self-regulating, advanced liberal subject, a child is not simply expected to achieve good grades. Rather, they should be managing every part of the educational journey, optimising the organisation of the learning environment and reflecting on their learning process and outcome. The results further highlight a certain emphasis on 'self-regulation'. The ability for self-regulation is again particularly problematised in the educational environment. Self-regulation therefore includes the ability to dedicate oneself to something that is experienced as not so interesting in a learning environment and that is void of any meaning to a particular child. The main aim of 'ADHD' therapy, thus, seems to be to adapt children to that void.

Of importance here is the idea of the intelligence quotient (IQ). Accordingly, children are assessed on their intellectual abilities and if there is a gap between IQ and projected performance in school, then the regime of practice around ADHD installs therapeutic measures. While, against the Apollonian image of childhood, poor performance has been considered as maladjustment against idealised notions of adjustment, in the current discourse the dichotomy is arguably rather around responsibility/irresponsibility (cf. Smith, 2012). The child, hence, is subjected to therapeutic measures in order to reveal their 'true self' against projected ideals that are based upon the assessed IQ. Not working towards such ideals would be regarded as irresponsibility.

Increasingly, the therapeutic interventions suggested to reveal the true self of a child are psychopharmaceuticals. The arguments in favour of such medical interventions are built around the idea that self-regulation and reflexivity, two core features of the Athenian image of childhood, are only possible in children labelled with ADHD while they are under the influence of psychotropic drugs. The findings suggest that while there are ethical concerns raised regarding subjecting children to medical interventions, they largely remain unheard.

While the hegemonic discourse argues that medication primarily addresses distress in children and is in their best interest, children themselves see medication more critically. However, this exploration has revealed that children's accounts are strikingly absent in the discourse around ADHD. In the 1139 press items analysed as part of this thesis only three articles describe the view of a child. This seems particularly problematic as previous research (see, for example, Cooper and O'Regan, 2002; Haubl and Liebsch, 2010a) has indicated that children's views of current discursive practices around ADHD, and particularly on the use of psychopharmaceuticals, are more critical than the actors given a voice in the hegemonic discourse.

This chapter has built on the knowledges that are entangled in the discourse around ADHD and that were elaborated upon in the previous chapter. It

analysed the conceptualisation of children alongside idealised images of childhood. I have argued that these knowledges and images are built around ideas of normality and in relation to scholastic requirements, both in terms of the school and, through homework in the private home. It is with these two social spaces and their relations to 'leisure' that the discussion now engages.

## 6 Governing Children within Social Spaces

*«Clearly the implementation of discipline at the societal level cannot be random and spontaneous; it requires a number of concerted strategies to ensure a uniform application and result. Primary among these is the exercise and manipulation of space»*

Chris Jenks (2005, p. 67)

### Introduction

So far this thesis has covered explorations regarding the knowledges and 'truths' that aim to render children governable, and the idealised images of childhood that governance is aimed at in the discourse on childhood ADHD in Switzerland. This chapter further extends the elaboration and is guided by the third specific research question, i.e. 'how are children labelled with ADHD governed towards specific ends?'. The chapter therefore examines the role of the organisation of social spaces in the governance of children. In terms of theory, in addition to the general governmentality orientation of this thesis, this chapter is particularly informed by the new social studies of childhood and its concern with spatiality that I discussed in the literature review (cf. **Childhood and the Concern with Spatiality**, p.28). Through analysing the discourse on ADHD with a focus on social spaces, this chapter aims to highlight how 'spatial imagery in ideologies of childhood' (Holloway and Valentine, 2000, p. 1) shapes contemporary understandings of suitable places and spaces for children to be in, and how these are designed in order to govern children towards specific ends.

One of the main social spaces to emerge in the data is the school. One in four images used in the articles examined in this thesis depict the child in relation to scholastic environments. That makes it the single most represented theme on the media plane regarding the discourse on ADHD in Switzerland. The further two themes that I have identified here are children in their spatial relations during leisure time and when at home in their families. The latter, though, is quite absent in the visual imagery, and is only referred to in terms of how children with ADHD are struggling in performing their homework. Consequently, this chapter is organised around these three themes of School, Family and Leisure.

In terms of data, each section presents an image that I have identified as representative of the relevant theme. As described in the introductions to the previous two chapters, I carefully read through all my data (i.e. texts from the media, the political and the parents' advocacy discourse planes) and coded texts that were relevant to each theme. A total number of 62 texts were coded to the theme School, 52 to Family and 27 to Leisure. Based on these texts I then undertook an in-depth analysis in order to identify sub-themes. Within these sub-themes I coded aspects that were constitutive of that subtheme. For instance, for the main theme School I identified Normalisation as a sub-theme and Assessment as one aspect (amongst others) of that sub-theme. Out of that analysis I then identified 35 text fragments as representative of these sub-themes. Most of these fragments refer to more than one aspect of the relevant sub-theme. In terms of discourse planes, 24 fragments were from the media, ten from the parents' advocacy and one from the political discourse plane.

Let us now turn to the findings, beginning with the theme of the School.

## **School**

When exploring the pictorial representations used in the media plane it becomes clear that the school plays a pivotal role in building the image of the 'ADHD child'. Without the institutional setting of the school much, if not all, of

the problematised behaviour that I discussed throughout the previous chapter becomes meaningless. This reflects the claim of Manfred Gerspach (2006) that ADHD can only be understood in the context of the school and its wider embeddedness in society. As I have argued in the literature review, the school is an important social space for children. Along with the home it is considered among the two single most important settings in the governance of children in the minority world. The concern with how children use and are shaped by spaces runs throughout the discourse. For example, a school psychologist, contemplating on ADHD and its treatment with methylphenidate, argues that

[t]he environment of a conspicuous {auffällig} child is indeed extremely important. There are big differences. On the one hand, some parents worry more than others. On the other hand, there are families, but also school classes that can cope with an overactive child much better than others... It is quite possible that a child may need treatment in one social setting and not in another (Kohler, 2002)

The argument 'that a child may need treatment in one social setting and not in another' supports the suggestion that the understanding of deviance is shaped by both cultural and political discourses. Furthermore, the reference to 'families' and 'school classes' again substantiates the idea that these are the most significant spaces of childhood in the minority (and, increasingly, the majority) world. I will, however, turn to the theme of the 'Family' in the next section and focus now on the reference to 'school classes'. The following image is representative of a body of images that seek to build the idea of the 'ADHD child' in the context of the school:



Figure 14: 'ADHD children are distracted more quickly and often react unexpectedly and impulsively' (Hirschberg, 2011)

The focus of this image is clearly on the boy in the middle who, rather than paying attention to the teacher in the front of the classroom, looks back to the camera. In that sense he shows 'deviant behaviour', since all pupils are expected to pay attention to what the teacher is presenting, which includes facing the teacher. This image thus provides a visual 'way in' (Banks, 2018, p. 19) to the argument brought up in the newspaper article, namely that children labelled with ADHD 'are distracted more quickly'. Such images are not merely decoration. Rather, they 'do work' (ibid.). In this case, the picture 'produces' the 'deviant child' (cf. Hamilton, 2001). It allows the reader to 'know' (Foucault, 1989) what Timimi and Leo argue has become a distinct category of childhood: the 'ADHD child' (2009, p. 1). Yet, on a closer look, there appears a second child in the top right of the image also looking back to the camera. To a certain extent this challenges the assumption of 'deviant behaviour', as looking back to the camera may also be regarded a normal, even expected, behaviour. The means of the production of this image, namely that there is a camera (and presumably a photographer) at the back

of the classroom, potentially attracts attention from some of the pupils. Whether or not their reaction is problematised depends on the way we interpret their behaviour.

This section is organised around the three sub-themes that I identified in my data in relation to the school, i.e. discipline, normalisation and optimisation. Let us consider these in turn.

## **Discipline**

As I discussed in the literature review (see **Discipline**, p.11), the school makes use of disciplinary power that subjects pupils to a regime that controls time, space and their bodies. I have suggested that ever since the introduction of free compulsory education, teachers have been confronted with a mass of children who are either unwilling to subject themselves to scholastic discipline or are not well prepared for it. The behaviour of such pupils, and their poor scholastic performance, has presented teachers with significant problems. Contemporary education seems to be no different. In a series of articles published by Elpos the authors mention in the editorial that

[u]ndoubtedly you will be confronted with educational problems as well as pedagogical ones. In a large class and under pressure to perform, a pupil usually reacts differently than at home. We know that it can be an enormous burden if you have more than one child who stirs up the lessons with [their] behaviour or special needs (Schenk-Leu et al., 2016, p. 5)

Children who disturb the classroom routine with their behaviour are consequently seen as deviant and subjected to further disciplinary measures. It is to these measures that the elaboration now turns.

### **Discipline through the Control of Space**

Defining and controlling the space used by children is an important part of discipline (Foucault, 1989). This includes the distribution of schoolchildren amongst and within educational institutions. In the context of Switzerland, education is free and compulsory and most children attend public schools (Educa, 2020). The distribution of children living in the catchment areas of schools follows specific rules that are defined by the relevant cantonal and



municipal authorities. While these rules may differ across regions in Switzerland, the common feature they share is that children and their parents have no say in the choice of the school to attend. This has been problematised by a non-governmental organisation formed of parents that calls itself Parents' Lobby. In response to a discussion on the media plane concerning children who show 'deviant behaviour', a representative of the Parents' Lobby argues that

[t]eachers have the opportunity to choose their school or pedagogical orientation because they can change jobs if they no longer like it at school. They can even be on sick leave for a longer period, for example because they suffer from psychosomatic symptoms (burnout). And a little later they can take early retirement - which some do - because school has become too much of a burden for them. The children, on the other hand, have no choice. Even if they suffer, they have to stay in school, in the place of horror from where they would like to flee. Apart from those parents that have sufficient financial means to send their child to a private school where [they] can recover and develop (Rauschmeier, 2008)

There is a rich body of literature in education on the importance of the relationship between teacher and pupil for successful learning and development in children. For example, both Maria Montessori (1974) and Rudolf Steiner (1907) emphasised the importance of relationships in education. Nevertheless, if there is an unfavourable match between a child who displays 'deviant behaviour' and their teacher, there is usually no escape from that situation until a standard transition (such as from primary to secondary school) occurs. It is against this background that the Parents' Lobby devotes itself to advocating for free choice of school on the political plane in Switzerland. Changing the status quo, though, would inevitably weaken the disciplinary powers that are based on the superiority of adults in the spatial regimes in schools. The distribution of individual bodies follows a certain logic that aims to optimise the surveillance of children through exposing them to the gaze of the teacher. These considerations have not lost any of their actuality. In an article published by Elpos a psychologist offers some guidance on how to organise the classroom that includes children labelled with 'ADHD' and argues that

[t]he first prerequisite for successful teaching is to focus on the organisation of the classroom:

- Checking the seating position. It might be a good idea to put pupils with ADHD close to the teacher and away from the window. Group tables are rather disadvantageous.
- Avoid stimulating the learning environment and the classroom with too many plans, posters, drawings and other objects.
- In the classroom, create several undisturbed workplaces through room dividers.
- Offer headphones as shields from stimuli and use them in class.

(Florin, 2016, p. 36)

Structure, therefore, is a central argument in the management of pupils in general, and particularly of those labelled with 'ADHD' and similar disorders. The 'thought style' here is apparent: if children do not perform well in a highly structured classroom, simply add more structure to manage them. But what seems to be ignored here is that while some pupils may perform well in a highly structured environment, others may be stressed by the same environment. Hjörne (2006, p. 194) termed structure a 'polysemous metaphor' to account for the ambiguity between how members of the 'thought collective' think of structure as being helpful to pupils labelled with 'ADHD', and how it may actually affect, even stress, pupils. Routine tasks, drill exercises and repetition are believed to help children with their learning experience. However, as DuPaul and Eckert (1997, p. 369) argue, 'one size does not fit all', and the assumption of homogeneity in both abilities and needs among children labelled with 'ADHD' is problematic. As mentioned in the literature review (cf. **School and Governance**, p.58), such practices seem to be effective in conveying to targeted pupils that they are indeed handicapped in a specific manner. They reflect the wider thought style and the biomedical literature that suggests that children with 'different brains' will just need more structure to deal with their challenges. Arguably, the wider medical literature is a powerful tool in organising contemporary classrooms and reflects the close alliance of psy-sciences and pedagogues in governing children within the 'regime of truth' around ADHD that was discussed throughout Chapter Four. As Devine (2004) argues, contemporary spatial

arrangements in schools reflect dynamics of power and control between children and adults and the lack of 'ownership' of the former. When asked, children reported that the classroom belongs to the teacher and the school to the principal. In other words, schools are designed as a 'place for children' rather than a children's place (Rasmussen, 2004, p. 161).

As I emphasised in the literature review (cf. **Control of Time**, p.12), other disciplinary measures to manage children's education are through the establishment of rhythms, the imposition of exercises and the regulating of cycles of repetition. It is to this aspect that the exploration now attends.

### **Discipline through the Control of Time**

Behaviour that has been labelled as 'ADHD' arguably challenges teachers in their aim to subject pupils to the rhythms of mass education. It is against this backdrop that suggestions on how to improve the absorption of such timed regimes by children labelled with 'ADHD' are visible throughout the discourse. For example, the Elpos publication *ADHD and School* advises teachers in detail how to increase children's compliance with homework requirements:

[a]s a teacher, you can use some routines to make children think about their homework more often.

1. Always write down homework in the same space on the blackboard, for example in the upper right corner. Reserve this space on the blackboard for homework notes only. An extra colour can also make it easier to direct attention.
2. Write your homework on the blackboard at the same time - for example, 10 minutes before the end of the last lesson. It's worth stopping by at the slower and more dreamy pupils to have a look at their homework book.
3. Always introduce the homework information with the same wording. For example: 'The homework for tomorrow is: ...'. Children with ADHD, but also children with a migration background, overhear sentences like 'for tomorrow, have...?' or 'finish it by tomorrow' (Grolimund and Rietzler, 2016, p. 43)

The level of micro-management here is impressive. It is a step by step instruction on how to inscribe the routines of homework into the child. Again, space (always use the same space on the blackboard) and time (always make the announcement 10 minutes before the end of the last lesson) are crucial in what Foucault termed the 'instrumental coding of the body' (1989, p. 153). Moreover, the use of an extra colour is suggested as a means to attract the attention of those children who may not be sufficiently attracted by the standard colour (which presumably is white). However, the 'slower and more dreamy pupils' will still require extra effort on the part of the teacher. Here, examination of their homework book is suggested. The homework book itself is again organised around space and time through allocating a dedicated space to each school day. Finally, the instrumental coding of the body should be done by using the same sentence every day to announce the pending homework. It is argued here that not only children with ADHD but also those who are immigrants to the country will overhear more vague sentences. This statement thus seems to stigmatise large groups of children in today's classrooms. Arguably, children labelled with 'ADHD' now account for almost 10 per cent of a class (cf. **Epidemiology and Prevalence Rates**, p.117), and the overall fraction of children with a migration background is 25 per cent (Swiss State Secretariat for Migration, 2019). It is highly questionable why, for example, a pupil who migrated from Germany should be less capable in high German than children without a background of migration. The generalisation and positivity here reflect the tendency to present arguments as absolute facts in what Fleck (1979, p. 112) called 'vademecum [sic] science'. As Cramond (1994) argues, such strategies may be counterproductive in that they potentially exacerbate the problematised behaviours of children labelled with 'ADHD'.

As I have mentioned above, the discipline in schools significantly draws upon the control of space, time and the body. After elaborating on the former two aspects, it is the practices around the body on which the examination now concentrates.

## **Discipline through the Control of the Body**

The body and bodily discourses are central to the power relations within schools. As I discussed in the literature review (cf. **Control of the Body**, p.12), children who do not manage to perform a high level of self-control are rendered problematic. Consequently, much of the discipline imposed on schoolchildren is about controlling their bodies. Arguably, the use of pharmaceuticals to amend children's behaviour, not only in the context of ADHD but also beyond, has also to be considered in the context of deviance and discipline in schools. In an article on the media plane portraying a private school and how it deals with children labelled with 'ADHD', a teacher mentions that one of their pupils

used to have to take three psychotropic drugs a day at the age of ten in order to function: Ritalin in the morning, an antidepressant at noon, a sleeping pill in the evening (Straumann, 2015b)

In Switzerland corporal punishment is considered lawful in the home under the parental 'right of correction' but is considered unlawful in schools (GIECP, 2019). In other words, while parents are still entitled to use a certain level of corporal punishment in the upbringing of their children, teachers are no longer allowed to recourse to it as a means of disciplining children. The recourse to psycho-pharmacology may therefore be interpreted as a logical consequence of the ban on corporal punishment. However, a certain controversy runs throughout the discourse. While some conceptualise the administration of pharmaceuticals in the context of ADHD as help (see, for example, Biederman et al., 1999), others see it potentially as punishment (Diller, 2009). Inge Schubert (2010), arguing from a historical perspective, explicitly sees the use of pharmaceuticals in this context as the replacement for corporal punishment of children. But how do children themselves perceive pharmaceutical regimes? Erica Augello (2010) argues that younger children (around 6 years) tend to internalise medicalisation and school practices less critically, while children who get medicalised later in their life (at around 10 years of age) tend to experience medical treatment for ADHD as an externally controlled intervention or even as an assault.

Such references to ‘externally controlled intervention’ and even ‘assault’ raise questions as to whether pharmaceutical interventions can be regarded as purely ‘non-corporal’. While Foucault acknowledges that the ‘[o]ld anatomies of punishment’ were abandoned through the recourse to psychopharmacology and the removal of penalties that imposed pain, he nevertheless asks ‘[b]ut have we really entered the age of non-corporal punishment?’ (1989, p. 101). This question resonates with a critical statement released by the German Society for Social Psychiatry on the use of psychopharmacology, including Ritalin, in children that argues that

the overhasty prescription of these drugs to children and adolescents who, due to their age, have only a limited capacity for understanding and consent, *constitutes bodily injury* and can therefore also have liability consequences (DGSP, 2013, p. 22, my emphasis)

However, due to the great freedom in prescription practices amongst medical doctors, it is highly questionable that even off-label prescriptions of psychopharmacological agents would lead to any liability consequences. As I argued in Chapter Four (cf. **The Privilege to Prescribe**, p.147), the therapeutic freedom that medical doctors are endowed with renders them nearly inviolable, even if it may be argued here that forced prescriptions may indeed constitute a ‘bodily injury’. The increasing tendency to use psychopharmaceuticals to control and manage the behaviour of children thus takes place within discursive practices that contain elements of both care and control. This dichotomy is constitutive of the ‘tutelary complex’. In social work this has often been problematised as the dilemma of the ‘double mandate’ (Meinhold, 2005), emphasising that all attempts to help and care also contain elements of control. The disciplinary measures that I have so far discussed are primarily concerned with governing children’s behaviour towards desired ends. In the endeavour to optimise children’s development there has been a tendency to subject them at an ever earlier age to such measures. It is to this aspect that the elaboration now turns.

## Optimisation

In an article published by Elpos a mother reports on the diagnostic processes of her children. While her son got diagnosed with 'ADHD', her daughter's diagnostic process was less straightforward. She reports that

[t]he kindergarten teacher suspected a dyslexia, although her linguistic expression was very good and her vocabulary grandiose. In order not to lose any valuable time, we should have her examined (Anonymous, 2016a, p. 22).

The concern with 'not losing any valuable time' highlights the emphasis on early identification in children. Hence, the idea of optimisation in children aims to subject children to diagnostic processes and treatment interventions at the earliest moment feasible in their lives. The primary driver for recruiting children earlier into educational settings seems to be the concern with preventing future risks. In a newspaper article a psychoanalyst and head of the Sigmund Freud Institute in Frankfurt argued that 'ever younger children are willing to violently resolve their conflicts and accept the risk of seriously hurting others.' (NZZ, 2009). To address this '[a] team of neurologists, educators, psychologists and psychoanalysts designed the Frankfurt Prevention Programme' (ibid.) The article further elaborated on the idea of early prevention:

Children from all social classes, including so-called high-risk families, were included. These include families of low socioeconomic status and neglectful families, but increasingly also children from apparently normal backgrounds with experience of violence.

The main question was whether a two-year psychoanalytic and non-drug prevention and intervention programme could significantly reduce the children's deviant and often violent behaviour. Within the framework of the programme, trained project staff maintain close contact with educators. They also hold discussions with the parents and offer individual therapeutic support and parent counselling in the day-care centres.

Five-year-old Peter also belongs to the circle of high-risk children. Again and again he beats and scratches other children. When his father loses his job due to illness, the situation escalates - apparently because he now fears that his father could be overstrained and send him to a children's home, Peter spits on a kindergarten teacher.

About 5 per cent of all children, particularly boys, display deviant behaviour like Peter already at kindergarten age. They beat weaker children and oppress them. Without treatment, they are at risk of slipping into crime as teenagers.

One of the reasons: Our brain is constantly changing into old age - antisocial and violent tendencies can therefore become more and more established through neuronal processes. The so-called plasticity of the brain is a characteristic in which synapses, nerve cells and entire brain areas adapt to changing environmental conditions.

This is how undesirable developments in behaviour and in the brain become established. 'That is why we have to offer children the possibility of preventing violence at a very early age,' says [the interviewee] (ibid.)

Again, the 'tutelary complex' is quite visible here, as the team consists of 'neurologists, educators, psychologists and psychoanalysts'. Their concern with normalising families is not new but there is a shift towards earlier intervention. The focus is now clearly on pre-school children. This reflects the contemporary concern with the early years of development (cf. Wastell and White, 2017). Through discussion and 'individual therapeutic support' parents are subjected to a process of surveillance and normalisation.

The reference to 'apparently normal backgrounds' suggests that the very idea of 'normality' is at stake here, and that potentially every family is at risk of raising children who will sooner or later display 'deviant behaviour'. This corroborates Allen Frances' (2013) claim that the idea of 'normality' is eroding and that this is leading to an expanding pathologisation of human behaviour. There is a clear future perspective here. In what Popkewitz and Lindblad (2004, p. 229) call 'historicizing the future', educational policies and governmental rationalities are aimed at forming the future citizen according to the idealised image of the Athenian child that I discussed in the previous chapter (cf. **Performing Advanced Liberal Subjectivity**, p.196). Developmentalism, together with epigenetics and neurosciences, allows this future ideal to be translated into idealised development stages in the present (McNamee, 2016). Arguably, the higher the expectations presented in the image of the ideal future citizen and the more the governance of children towards that image is regarded as a domain of both the family and the



school, the higher the pressure on these social spaces will be to identify deviance at an ever earlier stage. It is against this backdrop that the *German Guideline on ADHD* (DGKJP et al., 2018a) that I discussed throughout Chapter Four and the DSM (APA, 2013) are asking for early identification of ‘mental health disorders’ in children. In order to identify those deviations that are potentially undermining the future ideal, the tutelary complex needs a certain rationale to rate behaviour displayed by children. This is done using risk analysis. In the article above, five-year-old Peter hence qualified as a ‘high-risk child’, attracting particularly close supervision and therapeutic treatment in order to prevent him from ‘slipping into crime as a teenager’. Current behaviours, such as beating, scratching and spitting, are seen as predictors for serious troubles to come (Donzelot, 1980). Again, the idea of children as both ‘risky’ and ‘at risk’ is very visible here and emphasises the child’s state as a ‘human becoming’ that has yet to be formed to become a human being. Additionally, the reference to ‘[a]bout five per cent of all children’ represents the common strategy of presenting the prevalence of ADHD as a ‘given truth’ and serves as an epidemiological legitimisation to intervene. Moreover, the reference to ‘particularly boys’ reflects the gendered nature of ADHD. As Wastell and White (2017, p. 14) argue, the focus on preventing deviations in early childhood, combined with the ‘mythological significance’ of the first three years in life, will arguably lead to even earlier interventions. The alignment of developmentalism with both neuroscience and, more recently, epigenetics

promises to identify biomarkers of vulnerability and risk, thus creating the potential for state intervention to prevent ‘suboptimal’ human flourishing and to correct intergenerational social injustices (ibid., p. 5)

However, such approaches are not unproblematic. As Wells (2017) argues in her contemplations on autism spectrum disorders, the endeavour to optimise children’s lives may potentially lead to a revival of eugenics.

After considering how discipline and optimisation shape the lived experiences of children, the elaboration now attends to the last part of this section on the topic of the school i.e. normalisation.

## **Normalisation**

This section considers processes of assessment, pathologisation and inclusion that seek to normalise children, particularly in terms of their behaviour and their learning processes.

### **Assessment**

The technique of assessment is important in the contemporary government of children and allows comparison of their development against standardised development charts. As I discussed in the literature review (cf. **Assessment**, p.13), in the minority world children usually are subjected to this technique from the very moment they see the light of day. Once a child does not meet the expected standards, the procedure that follows may be a rather stressful experience. As a mother reports in an article published by Elpos,

Martin did not score high enough in the school maturity test, which is why the school psychology service was called in. Now the stress with the authorities began. Various tests were carried out with Martin, I had to answer thousands of questions and finally received the clear statement: severe ADHD, recognized by the disability insurance (Anonymous, 2016a, p. 21)

The school maturity test draws on a range of data that have been gathered by the psy-sciences (Rose, 1999) since the introduction of free compulsory schooling. What is really visible here is the idea of the 'normal child'. Ignoring that there may be huge differences in childhoods, both within and across countries (Cree, 2010), the current discourse permanently compares children to a normalised notion of the standard child. This 'iniquitous comparison' (James et al., 1998, p. 19) with their peers through constant evaluation and testing arguably leads to distress in many children, since both intra- and interpersonal deviations from the normalised, statistical development are rather common. In an interview given in a newspaper a paediatrician argues that

[m]any children show an unbalanced developmental profile, i.e. they are at different stages in different areas. A child just starting school may have the general knowledge of a 10-year-old, but [they calculate] like an 8-year-old, and has the language skills of a 5-year-old. Also the span between the children, who come with scarcely 6 and those with over 7 years into the first class, has an effect. The difference in development between children of the same age can be three years (Haag, 2005)

Although deviations from the 'norm' seem to be rather common, those who fail to meet the expected standards at any point of time in either education or bodily development face potentially strong sanctions and repercussions. In the case of Martin (see quote above), this included a series of further tests, a recognition of 'disability', the label of 'severe ADHD', the placement into a special education setting, various therapeutic efforts and the administration of psychotropic drugs (Anonymous, 2016a). Again, the 'psy knowledge' plays an important role here. In the context of Switzerland, the psychometric assessment of children falls within the responsibility of school psychologists and the trend is clearly towards more extensive assessment. As a school psychologist argues in an article on the media plane,

[t]oday not only weaknesses in performance are assessed, but everything, from school readiness, giftedness and test anxiety to behavioural problems - whenever pedagogy takes place under difficult conditions (Binder, 2010)

The reference to 'whenever pedagogy takes place under difficult conditions' suggests that the school is prepared only for the 'normal' child. All deviations from that norm, including giftedness, render pedagogy 'difficult'. Once those children who burden the school system through their deviation from the norm have been identified, they are pathologised. Arguably, even 'gifted children' are often rendered pathological through ascribing multiple labels to them, for example combining 'ADHD' with 'high IQ' (Rommelse et al., 2016). It is on these processes of pathologisation that the examination now concentrates.

### **Pathologisation**

As I argued in the literature review (see **Pathologisation**, p.14), the emphasis on even the smallest deviations from the norm have led to increased tendencies to render children as pathological. This in turn

produces a wide range of special needs services, including school social work, school psychology, speech therapy and play therapy. Such interventions reflect the construction of children as human becomings who need to be governed towards the idealised image of the Athenian child that I discussed in the previous chapter. However, the massive increase in labelling practices has also led to some critiques. In an interview on the media plane published in 2011 a paediatrician problematises the increase in the pathologisation of children:

[w]hen I opened my practice thirty years ago, hardly any child was treated for school problems. Today, more than fifty percent of all children receive therapies to address school performance issues. Something is wrong (Schmid, 2011)

This significant increase in therapies resonates with a substantial increase in prescription practices, particularly in stimulants, and the labelling of children in Switzerland with ADHD but also with anxiety, autism spectrum disorder and various 'learning disabilities' (Rüesch et al., 2014; Rüesch and Maeder, 2010). The interviewee, though, suggests that this tendency has more to do with unrealistic expectations and medicalisation than with differences in children:

[t]he kids haven't changed. More variations of the norm are simply defined as pathological... Many children are pathologised because there is a lack of knowledge in schools. Kindergarten children were referred to us because they could not sit quietly in a circle for three quarters of an hour. So one has a very clear idea that a kindergarten child has to be able to do that - but that is simply not developmentally appropriate (Schmid, 2011)

This statement may be best interpreted in the context of recent changes of education policy in Switzerland. The endeavours to harmonise the school system have led also to a reconstruction of kindergarten as a pre-school, and to the introduction of more formal spatial and temporal requirements. The 45 minutes during which a child is expected to sit still in a pre-school at age four, therefore, must be interpreted in the context of the contemporary demands of formal education. 45 minutes represents the length of a standard lesson in the school setting, and children are drilled at an ever earlier age to subject

themselves to the spatial and temporal requirements of contemporary mass schooling. After assessment and pathologisation, processes of inclusion aim to align children with 'special educational needs' (Lebeer et al., 2012, p. 69) into mainstream schools. It is to this aspect that the exploration now turns.

## **Inclusion**

Including children with 'special educational needs' into mainstream schools designates a recent shift in Swiss educational policy and practice (cf. **Inclusion**, p.14). While the idea of non-segregation sounds like the right ethical choice, the reality of mass schooling seems to undermine not only the individual interests of those children affected by processes of pathologisation, as described above, but also those of their peers. In a 2010 news article the then President of the Association of Teachers in the canton of Zurich

compared the inclusion of difficult and increasingly disabled children with the task of teaching chickens and eagles how to fly together. It could not be successful if the expectation was that the chicken would have to reach the flying altitude of the eagle (Wäckerlin, 2010)

It is remarkable how children are labelled as 'difficult' in the discourse around schooling. It may well be argued here, however, that there is no such thing as a priori 'difficult children' (Köhler, 2007), and that we should aim to understand children's behaviour as a meaningful expression of emotions, such as frustration and anger (Karnik, 2001). However, this labelling again reveals the long history of pedagogical thinking that children are either ill or badly educated (Donzelot, 1980), with a clear preference for illness in the form of various 'mental health disorders' and 'special education needs'. Comparing children with chickens and eagles only adds to that process of stigmatisation. Importantly, though, such labels are linked to the public health and disability insurance systems. In doing so they enable children to 'benefit' from resources that aim to compensate for the disadvantages that come with the label that has been ascribed to them. The following quote from an article on the media plane suggests that

[c]ognitive disabilities are now also frequently compensated for. For example, dyslexics are allowed to use a spelling program for German examinations and

ADHD sufferers, who are unable to concentrate, write the examination alone in a quiet room and get more time (Schweizerische Depeschenagentur, 2015)

Through partly exempting children from the spatial and temporal discipline of contemporary mass education, children labelled with 'ADHD' are thus granted 'compensation' for the 'deficits' associated with the label ascribed to them. The reference to 'disabilities' seems to further increase stigmatisation. Based on the vague assumptions the 'disorder' of ADHD is built upon, it appears to be highly questionable whether the ascription of the label of 'cognitive disability' is justified. This seems particularly problematic given the negative associations that come with such labels in contemporary societies of the minority world (and, presumably, beyond). In a critical media article a journalist sheds some light on the limits of such an approach:

[s]pecial needs pupil Sandro (13, name changed), who suffers from autism, Tourette syndrome and ADHD, has been attending a fifth class in Zurich since last autumn. During the school year there were numerous attacks on classmates (Binswanger, 2013)

It is remarkable how multiple ascriptions of labels are used here to 'include' a 'special needs pupil' into the standardised classroom. The option of simultaneous ascriptions of both 'ADHD' and autism spectrum disorder has only been introduced with the latest edition of the DSM (cf. APA, 2013, p. 65). The mix of these psychiatric labels is potentially stigmatising to the pupil but grants access to resources, such as specialised therapy, and the exemption from certain routines in the school setting. Arguably, the more children are being 'normalised' through assessment, pathologisation and inclusion, the more labels will be used and the more therapeutic measures will be installed. The significant rise in diagnostic labels across a broad range of mental health 'disorders' hence may be interpreted as, at least in part, driven by the quest for inclusive education (Hamre et al., 2018).

However, as the article regarding the situation of Sandro suggests, integration is not simply about asking 'special needs pupils' to adapt themselves to the system, but also one of inclusion: 'that the system offers a hand and creates space for maladjusted behaviour' (Binswanger, 2013). A

head of a secondary school argues, in another article on the media plane, that for a successful integration the following will be required:

early planning and bundling of resources, the formation of coherent teams, open-mindedness, flexibility and support through school social work (Wäckerlin, 2010)

The explicit reference to school social work is remarkable, as it is one of the very few references to the potential role of social workers in the context of the discourse on childhood ADHD in Switzerland (in total, only five items on the media plane and one article of the parents' advocacy group plane mention 'social work', but most of them only in passing). Arguably, as part of the tutelary complex, social workers play an important role in the government of families and their children. In the public discourse around childhood ADHD in Switzerland, however, they are almost completely hidden. This is indicative of power relations and highlights that medical doctors in general, and child psychiatrists and paediatricians in particular, are regarded as 'experts' in relation to ADHD. Arguably, some level of expertise has also been assigned to psychologists and educators, while social workers seem to be widely excluded from that status. This is in contrast to the research findings in France that I discussed in the literature review (cf. **Mass Media and the Internet**, p.45), where social workers, amongst other 'health professionals', are given a voice in the discourse on ADHD more frequently.

However, even if school social workers are involved, it seems highly unlikely that children in general, and those labelled with 'ADHD' and other 'special needs' in particular, can thrive in the setting of contemporary mainstream schools. Rather, research indicates that structural circumstances (cf. **Education and Structural Violence**, p.14) in the Swiss education system seems to negatively affect the educational journey of many children. For example, Schultheis, Perrig-Chiello and Egger (2008) problematised the reproduction of pupils' socio-economic backgrounds through the education system. Furthermore, statistics regarding pharmaceutical use in children released by the Federal Office of Public Health reveal that there are two

peaks in consumption of stimulants, at age 6 and age 12 (Hirschberg, 2011), which reflect the transitions from pre-school to school and from primary to secondary school. Above these transitional effects, the youngest children in a class are more likely to face medicalisation for behavioural reasons than their older peers (Nock and Hufschmid, 2017). Gendered aspects are also prevalent. For example, boys are less likely to reach high standards in education (Beglinger, 2008) but more likely to face pharmaceutical interventions for behavioural reasons (Rüesch et al., 2014). These statistics resonate with the research findings presented in the literature review on the potential pathologisation of immaturity and the effects of transitions as well as gender differences.

As I have argued earlier in this chapter, the processes of assessment, pathologisation and inclusion seek to normalise children against an idealised image of the Athenian child. Highlighting the outcomes of the prevention project discussed above, the journalist argues that

[f]or Peter, the project also led to a happy ending. He attends the third class, is a bright boy, but not violent. *He is a normal child* (NZZ, 2009, my emphasis)

The concern with the 'normal child' is prevalent throughout the discourse on ADHD in Switzerland. Normalisation is not only concerned with children, though, but also with their families. However, the very normalisation processes may alienate families from the idea of 'normality'. In a brief article published by Elpos a mother reflects on the nature of her family before her child was diagnosed with 'ADHD' at age 5: '[i]n short: We were fine, *we were a normal family*' (Anonymous, 2016b, p. 49, my emphasis). This brief statement impressively depicts how interventions by the tutelary complex may affect the self-concept of families. Before her child was diagnosed with ADHD the interviewed mother regarded her family as 'normal' but in the wake of the labelling and pathologisation processes that I have described above, that understanding changed.



## **Summary**

This section has elaborated upon the school as a site where children are governed towards the idealised Athenian image of childhood that was discussed in the previous chapter. Such governmental practices include subjecting children to disciplinary measures that aim to control the spatial, temporal and bodily aspects of pupils while at school. The findings indicate that many children are adversely affected by such structural characteristics of contemporary mass education, including the transitions from pre-school to school and from primary to secondary school. Moreover, this section has illuminated how children's lives are sought to be optimised at an ever earlier point in their lives. In the wake of educational reforms in Switzerland children are required to attend pre-school at age four in order to prepare themselves for the disciplinary regimes of the school. The final part of this section has elaborated on how the school seeks to normalise children through processes of assessment, pathologisation and inclusion. The results illuminate how these processes label a large number of children with various 'special educational needs'. While these labels may attract resources, they also tend to stigmatise children. The findings illustrate that such processes of labelling and pathologisation may adversely affect the self-concept of families through highlighting the 'otherness' (against an idealised notion of 'normality') of some of its members. It is to this social space of the family that the discussion now attends.

## **Family**

After the elaborations upon the social space of the school the exploration now focuses on the home of children, which in the discourse is generally referred to as 'family'. The examination first considers how the family, in the wake of the 'rise of the social', has become a site of government. This is then further elaborated upon through illuminating how governing takes place as a form of 'supervised freedom' (Donzelot, 1980, p. 47). The final part of this section considers the changing role of parents, and particularly mothers, in governing their children.

## The Family as a Site of Government

Although the family is considered an important space for children (cf. **Governing through Families**, p.17), familial concerns are almost completely absent in the current discourse on ADHD in Switzerland. The only reference found to the familial home is in relation to homework. This technology of control (Foucault 1991) has been operationalised by the DSM. Therefore, a child with ADHD is considered one who

[o]ften avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., [sic] schoolwork or homework...) (APA, 2013, p. 59)

Although critical educators (see, for example, Czerny, 2010; Robischon, 2019) continue to argue that children may perceive homework not only as boring and monotonous but also as completely meaningless, according to the DSM avoiding subjecting oneself to that technology of control is considered a symptom of a 'mental disorder'. As Donzelot (1980) argues, the private home has become an important factor in complementing the government of children in schools. From the perspective of governmentality, the technology of homework is a powerful means of assessing, monitoring and evaluating the behaviour of children. The diagnosis of ADHD requires the symptoms, as laid down in the DSM, to be present in more than one social setting. This means that apart from the behaviour displayed in the setting of the school, children are expected to show similar behaviour in the private home or in their free time. However, through extending the school setting into the private home by means of homework, the social spaces of the school and the family arguably merge to a certain extent, which in turn allows the diagnosis of ADHD based solely on the demands of contemporary education. This tendency is further aided through increasing extracurricular activities, such as out of school clubs, which further blur the boundaries between the school and after school child care (Smith and Barker, 2001). The following image was published in an article on the media plane that problematises the inability of children labelled with 'ADHD' to perform their homework according to the expectations of mass education:



Figure 15: 'It is difficult for many children to sit quietly during homework' (Straumann, 2012)

The image depicts a boy moving on his chair rather than concentrating on his homework. In doing so, this pictorial representation arguably pathologises externalising behaviour and mirrors the research findings that I discussed in the literature review that suggest that such behaviour is found more often in boys than in girls. However, such pathology-informed ascription processes mask the underlying causes that may trigger such behavioural patterns, including boredom (Sobo, 2009) or excessive educational demands (Ecks and Kupfer, 2015). Again, children's behaviour is rendered pathological here in a similar way to that discussed earlier in this chapter regarding the normalisation processes in contemporary mass education and such ascription processes in relation to homework performance prevent the

interpretation of these behaviours as a useful expression of children's inner state. Although the caption of the image mentions that it '[i]s difficult for many children to sit quietly during homework' (which, arguably, undermines the idea of a 'normal' docile child to a certain extent), the lack of this ability is nonetheless regarded as a 'symptom' of an underlying 'mental health disorder'. The importance of homework is further stressed in the discourse on ADHD through popular science. For example, in her article published by Elpos regarding 'ADHD in the school', a psychologist argues that

the homework situation is often perceived by the parents as particularly stressful. Here the dreaminess, the inattentiveness, but also the hyperactivity and impulsiveness of the children come to bear fully (Florin, 2016, p. 35)

Dreaminess, inattentiveness, hyperactivity and impulsiveness are thus traits in children that are rendered visible through disciplinary technologies, including homework, that mirror technologies employed in the context of institutionalised education. Once they have been rendered visible they are open to assessment and, in turn, treatment interventions.

As I argued in Chapter Four (cf. **Treatment**, p.138), these treatments are likely to be pharmaceutical, as the new *German Guideline on ADHD* (DGKJP et al., 2018a) proposes drugs even in cases of medium severity. The analysis of the discourse on childhood ADHD in Switzerland, though, suggests that such treatment interventions are aborted in many cases. The image above was published as part of an article (Straumann, 2012) on the media plane that problematises that half of the children on stimulant medication discontinue treatment after six months, one quarter even after two months. The statistics the article is based upon were released by the Federal Office of Public Health (hereafter FOPH) and raised some controversies, since the medical profession regards short term medication as ineffective. One of the cited 'experts', a child psychiatrist, identifies the missing support of parents as the cause of the large number of discontinued therapies:

'If the parents are left alone, the treatment quickly diminishes', says the psychiatrist. 'It is not enough simply to write a prescription, the treatment of

ADHD is more comprehensive and always involves close supervision and counselling' (Straumann, 2012)

The reference to 'parents' suggests that mothers and fathers are equally involved in the administration of psychotropic drugs to their children. However, as I indicated in the literature review, it is predominantly mothers who manage the medication in a child labelled with 'ADHD', while fathers tend to be more reluctant or even to sabotage the pharmaceutical 'management' of their children's behaviour. The quote above is reminiscent of what Donzelot termed '[t]he doctor prescribes, the mother executes' (1980, p. 18) and highlights how regimes of truth aim to foster 'scientific mothering' (Dowdeswell, 2014, p. 217) that is based upon the specific bodies of knowledges that I discussed throughout Chapter Four.

However, as indicated in the above statement, even though mothers tend to be more receptive to the medical model, they do not necessarily administer medication to their children as prescribed by medics. Hence the tutelary complex needs to closely supervise parents, and particularly mothers, to ensure that the child is consequently being medicated. As the 'mothering is now backed by the authority of medical science' in the wake of an ADHD diagnosis, mothers who do not follow treatment recommendations are considered as failing (Singh, 2004, p. 1203). Against this backdrop the role of social workers in this context is potentially seen as that of a 'compliance manager' (Janzen and Jeffery, 2013, p. 135). Hence, through managing mothers of medically labelled children, social work becomes part of a wider apparatus concerned with the government of populations (Foucault, 1991a) through pharmaceutical regimes. There runs, though, throughout the discourse, a certain ambivalence or even contradiction regarding the role of medication in parenting. On the one hand, the label of ADHD, and the medication that comes with it, offers refuge from the tendency to blame parents, and particularly mothers, for the behaviour of their children. On the other hand, parents are still regarded as in need of 'close supervision and counselling' (see above). It is to this ambivalence that the elaboration now turns.

## From Mother Blaming to Forced Screening and Drugging

Accounts of mothers who are receptive to the medical model of ADHD appear frequently in the hegemonic discourse. The following statement, in an article published by Elpos, exemplifies this:

Finally, the diagnosis! We found a new psychologist who tested Martin again thoroughly. Finally, we parents were informed what the four letters ADHD mean and which deficits our son had. Unlike my husband, I wasn't offended but rather happy. I didn't have to be ashamed anymore when other mothers with their children changed sides when we came. Now I could explain to them that Martin was 'ill' (Anonymous, 2016a, p. 22)

This brief excerpt of Martin's story, told from the perspective of his mother, impressively shows the potential of relief that the label of ADHD offers. Yet this relief reflects the gendered view of the pathologisation of behaviour displayed in boys, as mentioned above. While the father was 'offended', the mother was 'happy' about their son finally being diagnosed with ADHD. Through attaching 'the four letters ADHD' to her son, she finally was informed that her son was 'ill', which, arguably, to a certain extent, liberated her from responsibility for the behaviour displayed by her son. As I argued in the literature review (cf. **Governing through Families**, p.17), psychoanalytic explanations of children's behaviour tend(ed) to blame parents, and particularly mothers, if a discrepancy between 'ability' and (scholastic) performance in a child was detected. It is against this culture of mother blame that the relief, as described above, has to be interpreted. Offering relief from such discursive practices of blame, the medical model of ADHD was understandably well received by many parents.

It is noteworthy how the parents of Martin were informed by the psychologists of the 'deficits' of their son. This focus on deficits is characteristic of contemporary (American) psychiatry. This is most visible in the abandonment of the five-axis approach to diagnosis in DSM-5, which included the identification of strengths in a particular child and the elaboration of environmental factors shaping the lived experiences of that child. This deficit-based approach of the DSM-5 reflects recent developments within psychiatry

towards biological reductionism, which is arguably highly visible in the statement above (I discuss this in more depth in the next chapter, cf. **Introduction**, p.269). In addition, reference to 'deficits' also reflects the tendency to describe ADHD as a serious mental health issue. As discussed in the literature review (cf. **Consumerism and Advocacy Groups**, p.42), a brief genealogy of ADHD in Switzerland reveals that up to the 1990s the term Psycho Organic Syndrome (POS) was used to describe hyperactivity and inattentiveness in children. The diagnosis of ADHD then introduced the term 'disorder' and, through discursive practices, ADHD is now widely understood as an 'illness'. As indicated in the literature review (cf. **Diagnostic Criteria**, p.20), the DSM bases its diagnoses on a hierarchical model of constitutive elements, consisting of (i) symptoms, (ii) syndromes, (iii) disorders and (iv) diseases. Interpreted against this rationale, the move away from a syndrome (POS) to a disorder (ADHD) therefore suggests that although the aetiology of the cluster of symptoms that is being problematised remains elusive, a more adequate diagnosis has become possible because this cluster is not better accounted for by any other 'condition'. In other words, the behavioural patterns of 'inattentiveness', 'hyperactivity' and 'impulsiveness' displayed by children are believed to be best thought of as being 'ADHD', since no other 'condition(s)' would describe them more accurately. This approach has been critiqued for being too general and unspecific. Rather than having one underlying cause, counter-discursive accounts suggest there are multiple reasons why children show the behavioural patterns described by 'ADHD', and multiple 'conditions' explaining them (see, for example, Bonney, 2008b; Neraal and Wildermuth, 2008; Schmidt, 2019).

The reference to 'illness', however, indicates a further shift in the discursive construction of ADHD and reflects the tendency to depict ADHD as a 'given truth' constructed around the knowledges that I discussed throughout Chapter Four. As demonstrated in the quote above, such a construction enables a mother to refer to her child(ren) as being ill, and thus offers a relief from being 'ashamed' about the behaviour displayed by her child(ren). This reference to 'illness' is prevalent throughout the hegemonic discourse on

ADHD in Switzerland. In a newspaper article on the advantages and disadvantages of administering psychotropic drugs to children, a special education teacher even describes ADHD as a 'very serious illness' and argues that affected children often suffer from depression and are at risk of suicide (Cortesi, 2002). In a similar vein, a professor of medical science claims in an article on 'scientific factors' of ADHD published by Elpos that

[t]here is now sufficient scientific proof {Belege} to classify ADHD as an illness {Krankheit} with a neuro-organic basis (Weber, 2016, p. 16)

That ADHD is a valid 'illness' is therefore presented here as an 'objective truth' through reference to 'sufficient scientific evidence'. This is another example of how rather vague and potentially contradictory scientific findings about the nature of 'ADHD' have been translated into the 'certainties' of popular science. The popularisation of ADHD as an 'illness' is consequently a crucial prerequisite to relieving parents from blame. The blame, through this conceptualisation, shifts from the mother to the presumed genetic deficiencies within the child's brain that are supposed to be at the basis of ADHD. As Singh (2004, p. 1202) argues, this "'no-fault' model of behaviour" suggests that no one can be held responsible for behaviour that grows out of mental illness. Rather, within this particular narrative, the brain is the main and isolated actor causing the problematised behaviour and organic causes are not morally accountable. However, it is arguably questionable whether such an approach really frees parents from responsibility. For instance, Timimi (2006, p. 206) problematises that 'it never solves the nagging doubt in the back of a parent's mind that it is their fault'. This argument receives support in the discourse plane of the media. While the 'experts' who are cited throughout the media generally support the idea of a neurological basis for children's behaviour, responses to such statements in letters to the editor seem to be much more critical:

[t]he fact is that today many children are no longer educated, no limits are set for them. These children are displaying more and more behavioural problems because they seek and need boundaries (Pluess, 2003)



While the tutelary complex, including the profession of social work, is concerned with caring for children and their families and with supporting parents in their quest to raise healthy children, the strong focus on ‘the brain’ does not seem to free parents, and particularly mothers, from potentially oppressive ideologies of good motherhood (Singh, 2004). While they are increasingly being recruited as ‘strategic allies in assessment and management’ of mental health issues in children (Ma and Lai, 2014, p. 174), their participation in this alliance is not fully voluntary. There are increasing signs of pressure put on both children and parents in this context. For example, a parent expressed his concerns in an article on the media plane:

[o]ften teachers or school principals strongly motivate parents to support their children with medication. To such an extent that parents have the feeling that it is a matter of an order {Verordnung}, and this is a violation of competence (Kempf, 2018)

This is one of the very few accounts on the media plane that problematises the pressure on parents to get their children assessed and, often, treated with stimulants. Once the school has expressed its concerns, parents are then often ‘strongly motivated’ to consult with a child psychiatrist or a paediatrician. The article also cites a director of a child psychiatric clinic in response to the concerns raised by parents. The director admits that there are more and more parents coming for an assessment but sees this as a positive development:

[o]f course, there is a sensitization among the teachers, today’s teachers know the clinical picture of ADHD, fidgety Philipp disorder {Zappelphilipp-Störung}, as they used to say. They know now of course, okay, here we could do something. They then inform the parents accordingly and say that we have already had good experiences with other children who have received Ritalin (Kempf, 2018)

It is remarkable that the focus here is neither on the child nor on the parent, but on teachers. They are those who ‘know’ (Foucault, 1991a), and they are those who have had ‘good experiences’ with children taking Ritalin. This focus on teachers and the educational environment is further highlighted by the proposed policy change that is being discussed in the article. Thus, a

recent motion presented to the parliament of the Canton of Basel-Country has proposed a change to the education law:

[t]he diagnostic assessment {Abklärung} usually takes place with the consent of the natural or legal guardians. If they refuse the diagnostic assessment, the Education, Culture and Sports Directorate can, at the request of the school management, order a diagnostic assessment if the student's development opportunities {Entwicklungsmöglichkeiten} or the school environment would otherwise be significantly affected (Cantonal Parliament of Basel-Country, 2018)

This is a further example of how the tutelary complex is concerned not only with caring for children and their parents but particularly also with controlling them, reflecting the 'double mandate', as discussed earlier in this chapter. The new law proposes to undermine the right of parents to determine what is best for their children. Rather, the school is being empowered to force parents to subject their children to diagnostic assessment and presumably later treatment with psychotropic drugs. Accordingly, the pressure on both children and parents is justified, based upon claims that either the child's 'development opportunities' are at risk, or the school environment is 'significantly affected'. Interestingly, this is being presented as an either/or rationale, which is in opposition to the discourse on risk identification and management that sees children as both at risk and being risky.

Furthermore, the reference to 'development opportunities' reflects the tendency of the tutelary complex to see children as either ill or badly educated (cf. Deleuze, 1980). Through the shift from mother blaming to blaming the brain of the child, though, the focus is now arguably on 'illness' rather than on the quality of upbringing. In other words, if there is a discrepancy between intellectual abilities and scholarly performance, then the child must be ill. This rationale then serves to justify forced screening and treatment. Even more problematic, however, seems to be the reference to the school environment. While it could be argued that the particular setting (school, teacher, classmates, syllabus etc.) may be undermining the child from prospering in his or her educational journey, the argument is presented the other way around. Hence, the child becomes potentially regarded as a

risk to the school environment that needs to be controlled and, from that point of view, forced screening and treatment seem to be logical consequences. While the proposed change in the education law has not been passed by the cantonal parliament, it nevertheless indicates the direction the discourse is heading in.

## **Summary**

This section has elaborated upon the family as a site of government. I have argued that the technique of homework extends some of the disciplinary powers in schools that I discussed earlier in this chapter into the private home. Moreover, I have argued that while parents, and particularly mothers, may feel some relief from the ‘blaming culture’ through the medical model of ADHD, they are still subjected to interventions by the tutelary complex that aim to govern families towards specific ends. In the light of idealised notions of the Athenian child, parents of children labelled with ‘ADHD’ are subjected to both care and control by the tutelary complex in their parenting. Increasingly, this extends into all aspects of life, i.e. not only to the social spaces of the school and the private home, but also to children’s (and their families’) leisure time. It is to this ‘government through leisure’ that the exploration now attends.

## **Leisure**

The previous two sections have elaborated upon the government of children in the temporal and spatial contexts of the school and the family. This section expands the analysis by examining how children are governed through leisure. After some elaborations regarding how activities such as chess and music are aimed at fostering Athenian characteristics in children that have been discussed in the previous chapter, this section considers children’s autonomous use of space and offers some insights into children’s own views on leisure.

## Governing through Leisure

The following image was published in a news article with the title 'Playing chess makes children quiet' (Zilic, 2011):



Figure 16: 'Seven-year-old Maximilian is concentrated on the chessboard. Before he found his way to the game of kings, he was a very lively child' (Zilic, 2011)

The caption of the image reads

[s]even-year-old Maximilian is concentrated on the chessboard. Before he found his way to the game of kings, he was a very lively child (ibid.)

The image indeed shows a child in a state of concentration, sitting quietly at a table and playing with chess figures. These figures, though, are not neutral but gendered. The mother of the boy who is the president of the chess club argues that chess is suitable for both girls and boys. However, while boys play chess with the 'Dragonball' version, girls use a chessboard with a 'Hello-Kitty' appearance. This reflects how social spaces designed for and experienced by children are constrained by a number of aspects, including gender and age, class, ethnicity and risk (Cree, 2010; McNamee, 2016; Wells, 2009). These constraints also encompass a certain understanding of norms and values. For example, boys are expected to measure their strengths without using 'violence':

[w]hen asked what makes chess more exciting for children than a computer game, the president gives a clear answer: 'It's also about judging strength and winning - but without violence. You also learn for life, because you can't afford to make mistakes.' This is especially attractive for the boys (Zilic, 2011)

The reference to 'winning without violence' reflects a certain tendency to regard children, and particularly boys, as being dangerous. Teaching them how to win without using 'violence' therefore serves as a means of risk management. As Corker and Davis (2001, p. 88) argue, while children are generally subjected to risk assessment and management on a fluid basis, those labelled with 'disabilities', including 'ADHD', are regarded as 'risky per se'.

Furthermore, the reference to 'learning for life' reflects contemporary endeavours to link play in children with educational objectives. The ultimate goal, then, is to 'learn for life'. This reflects the aims of contemporary governmental activities to foster idealised Athenian subjectivities. Children are consequently expected to reflexively shape their own biography through educational measures in order to invest in their 'emancipatory project of learning to be a self' (Rose, 1999, p. 242). The reference to the future is arguably informed by middle-class values. As Edwards (2001, p. 12) argues, while working-class childrearing is more rooted in the present, middle-class parenting tends to be 'oriented to the future and engaging with reflexive individualisation'. The chess course can thus be regarded as the accumulation of cultural capital (cf. Bourdieu, 1984) to promote social mobility. However, members of the middle-class are in a better position to invest in the cultural capital of their children as they have the financial means to do so. The rather high membership fees (660 CHF, i.e. approximately 520 GBP per semester) may arguably prevent many children from working-class backgrounds from learning chess at this club. However, the mother of Maximilian argues that

[t]he fact that chess promotes the concentration of the little ones and is still fun, legitimises the price (Zilic, 2011)

The reference here to ‘concentration’ reflects the tendency of the tutelary complex to regard play as both an indicator of child development and a (therapeutic) means of intervention (Miller and Kuhaneck, 2008). Labelled with ‘ADHD’, Maximilian’s development was regarded as out of the ‘norm’. The intervention in the form of chess training, then, sought to transform him from being a ‘very lively child’ into a boy who ‘is concentrated’ (Zilic, 2011). The success of the intervention is measured in terms of behavioural changes towards normative expectations. The article argues in the lead text that

[s]even-year-old Maximilian has improved his performance at school because he plays chess (ibid.)

The reference back to school performance supports the claim of Smith and Barker (2001) that the boundaries between school and after school activities are more and more blurred, while recreational activities are increasingly aimed at rendering the child more docile and adapting them to scholarly demands. These shifts in the design of leisure activities corroborate the argument of Montgomery (2009) that there runs a certain contradiction throughout the discourse on children’s play. While children’s activities in the context of ‘play’ are meant to be ‘consigned to the realms of the meaningless and carefree’, they are also regarded as ‘a serious thing’, helping children to reach developmental goals (ibid., p.142).

Moreover, the reference to ‘still being fun’ indicates that there is a certain relationship between play and fun, which could be potentially capitalised upon in the design of children’s leisure time. In their ethnographic study of out of school clubs Smith and Barker (2001) argue that many of these clubs explicitly emphasise the educational benefits of the ‘fun’ activities they offer. Simultaneously, schools may aim to integrate activities that promote ‘learning through play’ (Wong and Goh, 2014). Indeed, ‘fun’ seems to be an important factor for children regarding ‘play’. In their study *Children’s Perceptions of Play Experiences and Play Preferences*, Miller and Kuhaneck (2008) identified ‘fun’ as the primary rationale for children both choosing an activity

and for designating it as being 'play'. The absence of 'fun' led the children to perceive an activity as being 'non-play'.

Playing chess, at least in the described situation of Maximilian, aims to render the body docile through a 'fun activity', to increase the ability to show sustained attention and to finally increase scholastic performance. This resonates with the suggestions brought forward by Elpos (2016d) for how parents might organise the leisure time of their children labelled with 'ADHD'. Chess is accordingly perceived as an activity that increases children's cognition, concentration, social skills, self-worth, and impulse control. While chess is arguably a rather sedentary activity, more physical types of leisure are particularly suggested to foster 'self-control' in children:

[a]s a balance to sitting still at school, exercise in leisure time is important. It makes sense to practice sports that combine the pleasure of being active with a high degree of self-control... Endurance sports are recommended for hyperactive children/young people in order to be able to live out their urge to move (ibid., p.70)

Sport, hence, is regarded as a means of countering the effects of the paucity of physical activity in schools. Rather than questioning the need to sit still for hours, which seems to be in contrast to the needs of most children and potentially undermines their learning process (Robischon, 2019), the 'hyperactivity' of specific children is individualised and rendered problematic. The link to 'self-control', then, emphasises the Athenian ideal of subjectivity that is sought to be fostered in children, namely prudent, reflective people who act only after careful consideration of options and the advantages and risks these bring.

In the same article cited above, music is similarly proposed to produce Athenian subjects:

[m]usic is a successful method of making children calmer. Learning an instrument improves fine motor skills, body coordination, balance and auditory perception. If the child makes music in a group, social competence is promoted at the same time. In music therapy, the child processes conflicts and problems with sounds, noises and instruments. Through music, [they] learn something about [them] and can achieve a positive change in behaviour

because it promotes [their] resources and emotional access to [themselves] (Elpos, 2016d, p. 69)

Far from being an unstructured time, children's leisure is therefore regarded here as a means of improving the child's behaviour in the light of scholastic requirements and expectations. Again, the main concern seems to be to calm children, i.e. to render their bodies docile. Additionally, the reference to 'therapy' indicates that leisure and therapy are increasingly being meshed, making it difficult to draw a distinction between work, leisure, education and socialisation (Montgomery, 2009). This development also affects the way children use social spaces for their leisure. It is on this aspect that the exploration now concentrates.

### **Children's (Autonomous) Use of Space**

The use of social space by children is significantly shaped by adults and, in particular, parents. In a newspaper article entitled '[p]arents don't want to let kids go outside' (Guillain, 2013), a 'neuro-paediatrician' problematises that children spend less and less time outdoors, arguing that this 'leads to mental illnesses and damage to the musculoskeletal system'. He further argues that the reason for this development lies in

the increased media consumption of children and the behaviour of many parents: 'Parents are afraid to let their children out into the open. They are often really neurotic and see dangers everywhere. Additionally, the spare time of many children is tightly organized' (ibid.)

Indeed, research suggests that children tend to spend an increasing amount of their time in the home (cf. James et al., 1998). As Smith and Barker (2001) argue, this development is not only material but also ideological, in that the family home is considered the best place apart from the school for children to spend their time. This 'ideology of domesticity' (Laurie et al., 2014) propagates the family home as a safe space, while simultaneously depicting public spaces as being risky. The fears of parents and, more generally, adults regarding children and their independent use of public space are twofold. On the one hand, childhood is conceptualised as a stage of



innocence and vulnerability, and the unsupervised use of space may thus expose children to potential dangers. On the other hand, children themselves, and their unruly behaviour, may undermine adult control of such spaces (Holloway and Valentine, 2000).

A further concern raised in the above citation is the highly structured and scheduled time of children. Children's 'leisure time', i.e. the time not spent at school, is increasingly being institutionalised. Organised leisure time, such as sports or music lessons, reduces the time for unsupervised play by children. In their study of children's experience of socialisation in the canton of Geneva, Montandon (2001) found that more than one third of the children who attended the public education system were also enrolled in various extra-curricular activities organised by the school.

Furthermore, organised activities, such as music and other lessons and sports, occupied children's time, particularly those from a middle-class background. Montandon argues that in the wake of more recent individualisation processes, children are involved in decision-making regarding their education and leisure time. However, while such participative approaches empower children to a certain extent, their lives 'are not necessarily less constrained, and much more is expected of them' (ibid., p. 106). Against this backdrop Ennew (1994) argues that the lives of children are, similarly to those of adults, increasingly compartmentalised. Through what she terms 'curricularization' (ibid., p.133), the school timetable is extended beyond the spatial and temporal confinements of the school into the whole of children's lives. Arguably, part of this compartmentalisation of leisure time, particularly in younger children, has to do with providing child care for the time between children finishing school and their parents finishing work (Horgan et al., 2018). In the wake of these structural shifts the idea of 'free time' tends to disappear in favour of more 'constructive' activities.

Moreover, the concern with 'increased media consumption' (see quote above) resonates with significant attention in both academic and popular literature (McNamee, 2016). Particularly, violence within the context of video

games and its possible adverse effects on children has been the subject of extensive sociological enquiries. The assumption that media use is harmful and passively absorbed by children, however, has been challenged (see, inter alia, Hadley and Nenga, 2004). Rather, children use media to enact, explore and resist cultural values and subjectivities, such as being a 'good pupil'. While the fears regarding media use by children have been substantively addressed in research, there has been significantly less attention paid towards the meanings of media use to children and the reasons why they choose to interact with them. In her account, drawing on Foucault's notion of 'heterotopia', McNamee (2000) argues that while childhood is increasingly subjected to boundaries, children create heterotopias, i.e. other spaces through the use of media. Such other spaces, she further argues, provide children with the opportunity to experience the adventures that they are no longer permitted to have in any real sense due to the increasing boundaries they are subjected to.

This lack of research on children's own views on their use of media is mirrored in the broader discourse on the media plane regarding leisure. What do they perceive as play and leisure? What spaces do they like? In the same article cited above, a representative of the Canton of Berne Department of Elementary School refers, at least in passing, to children:

'[t]he canton supports extracurricular learning locations and is committed to ensuring that children get to know nature not only through teaching aids'. In addition, many schools work together with the children to make playgrounds in school buildings and kindergartens as attractive as possible. The feedback from parents and children is usually positive (Guillain, 2013)

The reference to 'extracurricular learning locations' emphasises the tendency to blur children's school and leisure time, as discussed above. Additionally, it emphasises that their leisure time should be subjected to 'learning' rather than just playing. While the participative approach allows children to co-design playgrounds in schools to a certain degree, the wider structural expectations and restrictions that the discourse around children's leisure time brings will hardly be challenged by their views. As Hart (2008) argues,

children's participation may take a number of forms. To visualise this he designed a hierarchical 'ladder of participation'. The 'rungs' of this model ladder range from manipulation to child-initiated and child-directed forms of participation. Arguably, many political projects, such as the design of playgrounds, keep children's involvement at the lower end of the ladder, which, according to Hart, is considered 'non-participation'. This again reflects the power imbalance between children and adults. While children may at least be consulted in the cantonal projects mentioned above, they may also be deliberately excluded from such processes. Moreover, as Holloway and Valentine (2000) argue, in order to discourage children from using public spaces, they may be designed in a way that makes them unattractive.

## **Summary**

The final section of this chapter has explored how children are governed through leisure. I have argued that 'extracurricular' activities tend to further blur the boundaries between work and leisure. Furthermore, these recreational activities are increasingly aimed at rendering the child more docile, in the light of the demands that contemporary education puts on children. It then went on to elaborate upon how children use social spaces autonomously. The findings highlight that through increasing compartmentalisation of leisure time, children are facing diminishing 'free time' in favour of more 'constructive' activities. Moreover, while children tend to spend less time outdoors, they may increasingly create and use their own virtual spaces. In addition, the results suggest that children themselves are largely absent in discourses regarding the design of recreational spaces, echoing the marginalisation of their voices that I have problematised throughout this research.

## **Conclusion**

This chapter has explored how the design of social spaces aims to govern children in general and those labelled with 'ADHD' in particular, based on the knowledges discussed in Chapter Four, and towards the idealised image of

the Athenian child as elaborated upon in Chapter Five. The exploration of visual data highlights a substantive concern with the school environment, as one in four images represents the child in relation to this particular social space. The further two themes that I have identified here are the family and leisure.

The findings illustrate that discipline is an important means of organising the school, both in its spatial and temporal dimensions. For instance, pupils are distributed both amongst and within school buildings, without them or their parents having a say in the matter. Much of the discourse problematises how children labelled with ADHD tend to resist routine tasks, such as monotonous schoolwork. This resonates with previous research that claims that ever since the introduction of free compulsory education, teachers have been confronted with children unwilling or unable to subject themselves to scholastic discipline (Donzelot, 1980).

The results further highlight that the standard advice for teachers in such situations is to impose even stricter structures and time management on pupils. For example, detailed instructions on how to instil the routines of homework into the child aim to standardise both spatial and temporal aspects of the 'instrumental coding of the body' (Foucault, 1989, p. 153). A high level of bodily self-control is regarded as maturity in children and an important aspect of advanced liberal subjectivity, as represented by the image of the Athenian child. Pupils who do not meet these disciplinary requirements of the school, though, are problematised in a dual pathology. They are seen as both children at risk and as being risky children. As has been argued in previous research (Caputo, 2007), it is against this duality that disciplinary measures are being legitimised. In this context, the use of pharmaceuticals to amend children's behaviour has been legitimised within the hegemonic discourse as a means of helping children labelled with ADHD. Yet, the analysis of counter-discourse challenges this assumption and considers such practices potentially as a form of punishment (e.g. Diller, 2009). It has been argued in previous work that the dichotomy of care and control is constitutive of the

tutulary complex (cf. Rose, 1999). In social work this has often been problematised as the dilemma of the 'double mandate' (Meinhold, 2005), emphasising that all attempts to help and care also contain elements of control.

The exploration has further revealed a certain emphasis on optimisation in the context of the school. This is most visible in the tendency towards recruiting children at an ever-younger age into pre-schools in Switzerland, particularly in the light of recent shifts towards harmonising the school systems across the cantons (EDK, 2015). In political debates, extrafamilial care and the endeavour to identify deviations from the 'norm' as early as possible further support earlier enrolment. This reflects the idea of malleability and perfectibility in children, which are shared elements in discourses around different images of childhood, such as the Apollonian or the Athenian child (cf. Jenks, 2005; Smith, 2012). Early identification, consequently, stresses the idea that no time should be lost in the optimisation of children through therapeutic interventions.

The results further illustrate that processes of assessment, pathologisation and inclusion seek to normalise children against the image of an idealised child. For example, the school maturity test assumes that all children develop according to a certain predictable pattern, which is primarily shaped by the genetic epistemology of Jean Piaget (1971, 1964, 1952). Such testing establishes the otherness in children and renders them pathologic and in need of therapeutic interventions. This 'iniquitous comparison' (James et al., 1998) with their peers through constant evaluation and testing arguably leads to distress in many children, since both intra- and interpersonal deviations from normalised, statistical development are rather common (cf. Huff, 1991, 1954). This in turn produces a wide range of special needs services, including school social work, school psychology, speech therapy and play therapy. The members of the 'tutulary complex' (Donzelot, 1980) in general, and psychologists, paediatricians and child psychiatrists in particular, play a

pivotal role in what may be termed the pathologisation of otherness in children.

Against this backdrop there has been a significant increase in therapies, which in turn resonates with a substantial increase in prescription practices, particularly for stimulants, and the labelling of children with psychiatric disorders, of which ADHD is a rather common one. The findings suggest that such regimes of practice are also shaped by structural changes. For example, the endeavours to harmonise the school system have led also to a reconceptualisation of kindergarten as a pre-school and to the introduction of more formal spatial and temporal requirements in early education. Children are now expected to be able to sit still for 45 minutes in pre-schools at age four years and those who do not meet these standards are rendered problematic and subjected to therapeutic interventions.

Furthermore, structural violence, such as transitions from pre-school to school and from primary to secondary school, seem to have a negative impact on children, which is visible in statistics on prescription practices around ADHD. In addition, gender seems to play a pivotal role, with boys much more affected by both identification of and medical treatment for ADHD than girls.

The findings further highlight a certain shift towards inclusive education. This approach aims to educate all children in mainstream schools and to prevent the segregation of children because of their 'special educational needs'. While the idea of non-segregation sounds like the right ethical choice, the reality of mass schooling seems to undermine not only the individual interests of those children labelled with 'special educational needs' but also those of their peers. Moreover, I have argued that inclusive education potentially drives labelling processes in children, since such labels bring resources (such as therapies) along with them.

Although the family is considered an important space for the socialisation of children, familial concerns are almost completely absent in the current

discourse on childhood ADHD in Switzerland. The few pictorial representations of the family home are in relation to homework. Homework plays a pivotal role in the management and supervision of children in contemporary education, and arguably extends the medical gaze and the panoptic surveillance into the sphere of the private home. The results highlight that the boundaries of the school and the family are increasingly blurred, which in turn allows the diagnosis of 'ADHD' to be based solely on the demands of contemporary education.

Through what Donzelot (1980) calls 'supervised freedom', children and their parents are governed towards specific ends perceived as desirable. This governance includes the prescription of psychotropic drugs. But while mothers tend to be more receptive to the medical model of ADHD, they do not necessarily administer the medication to their children as suggested by doctors. Consequently, the 'tutelary complex' is endowed with the task of supervising families. It is in this context that social workers are potentially seen as compliance managers.

The findings suggest that changing images of childhood affect parents, and particularly mothers, in the upbringing of their children. By attributing troubling behaviour in their children to neurobiological forces outside their control, children are reconceptualised as 'ill' rather than 'bad'. This has offered a 'label of forgiveness' (Reid and Maag, 1997) in that mothers are no longer to blame for the behaviour of their children. The blame, hence, has shifted from the mother to the presumed genetic deficiencies within the child's brain. This resonates with previous research. For example, Singh (2004) argues that this 'no-fault model of behaviour' suggests that no one can be held responsible for behaviour that grows out of disorder. Rather, within this particular narrative, the brain is the main and isolated actor causing the problematised behaviour and organic causes are not morally accountable.

However, it is arguably questionable whether such an approach really frees parents from blame. While the hegemonic discourse and the 'experts' voiced

within it clearly support the hypothesis that children labelled with 'ADHD' are in distress from an illness that determines their behaviour, the exploration of letters to the editor suggests that the wider public does not necessarily back this claim. Additionally, the tutelary complex still aims to govern families and considers parents at best as allies in the assessment and management of 'mental health' in their children. In this context the results suggest that there are increasing signs of pressure put both on children and on parents to assess and drug children.

The findings illustrate how children's leisure time is shaped by an Athenian image of childhood that emphasises agency, participation and self-regulation. For example, children are subjected to chess lessons that aim to teach them how to win without using violence and how to 'learn for life'. The former is concerned with linking children's leisure time to educational goals. Children are therefore expected to reflexively shape their own biography through educational measures in order to invest in their 'emancipatory project of learning to be a self' (Rose, 1999, p. 242). Furthermore, teaching children, and particularly boys, how to win without violence is aimed at reducing risk. Again, the discourse is shaped here by the idea of children being both vulnerable and a potential threat.

The focus on the educational value of play in children that the results illuminate indicates the tendency of the tutelary complex to regard play as both an indicator of child development and a (therapeutic) means of intervention (cf. Miller and Kuhaneck, 2008). There runs, though, a certain contradiction throughout the discourse on children's play. While children's activities in the context of play are meant to be a carefree occupation in children, they are also regarded as a means to help children reach developmental goals. For example, Elpos (2016d) promotes chess as an activity that increases children's abilities, including cognition, concentration, social skills, self-worth and impulse control. This again resonates with an image of childhood that aims to foster advanced liberal subjectivities in children.



Discursive practices thus increasingly align leisure time in children with scholastic requirements and expectations. For instance, some forms of leisure time are proposed to counter the effects of the paucity of physical activity in schools. Moreover, the analysis of the discourse around ADHD suggests that leisure and therapy are increasingly being meshed, making it difficult to draw a distinction between work, play, education and socialisation. This tendency has been problematised in earlier research (e.g. Montgomery, 2009).

The results indicate that children tend to spend an increasing amount of their time in the family home. Under an 'ideology of domesticity' (Laurie et al., 2014), the home is propagated as a safe space, while public spaces are rendered problematic. Again, the arguments are twofold. On one hand, childhood is conceptualised as a stage of innocence and vulnerability, and children are exposed to potential dangers when they use space unsupervised. On the other hand, children themselves and their unruly behaviour may undermine adult control of such spaces.

In addition, children's leisure time tends to be increasingly institutionalised and timetabled, which reduces their time for unsupervised play. While children are involved in the decision processes regarding the organisation of their lives, the idea of 'free time' tends to disappear in favour of more 'constructive' activities in the light of an Athenian image of childhood. This resonates with previous research by Montadon (2001) who argued that while participative approaches empower children to a certain extent, they do not necessarily free children from constraints while simultaneously rendering children responsible for their choices.

The findings further highlight that technological advancements, including smartphones and the Internet, potentially provide children with new means of communication, forming friendships and creating their own spaces. Again, the duality of children being at risk in such virtual spaces and being a potential threat to others shapes the discourse. The common theme running throughout the discourse around leisure time in children, hence, is the

anxieties of adults regarding children being both at risk and risky when using space autonomously, be it virtual or physical space. Again, what is largely absent in the media discourse are the views of children themselves.

This chapter has built on the knowledges and images that were elaborated upon throughout the previous two finding chapters to explore how children are governed within social spaces. I have argued that these knowledges and images are built around ideas of 'normality' and employed in ways that increasingly mesh notions of therapy, leisure and work (including home- and schoolwork) in children's lives. The next chapter analyses these findings, derives implications for social work, discusses possible perspectives for social work, offers some considerations regarding limitations and possible avenues for future research, and reflects on the process of conducting this research.



## **7 Discussion**

This chapter brings together the main findings across the three analytical chapters. It then draws out implications for social work and offers three perspectives for the future development of social work. This is followed by contemplations on limitations and future research and some concluding remarks.

### **Summary of Main Findings**

As already stated, this thesis was guided by an overarching research question as well as three more specific questions. The overarching question was: How has the concept of childhood ADHD been established and maintained in the discourse in Switzerland to date? The more specific research questions were:

- (i) How are children labelled with ADHD rendered knowable and governable?
- (ii) How are children labelled with ADHD conceptualised and represented?
- (iii) How are children labelled with ADHD governed towards specific ends?

This section considers the more specific research questions in turn and aims to bring together the key findings. These findings are discussed in relation to the research that was introduced in the literature review, indicating how this thesis contributes to the existing body of knowledge on childhood ADHD. Furthermore, the use of analytic concepts, including governmentality (Dean, 2010; Foucault, 1991a; Inda, 2005; Rose, 1996) and some further work of

Foucault (2002, 1991b, 1989), Fleck (1979) and scholars of the new social studies of childhood strand (Holloway and Valentine, 2000; Jenks, 2005; Smith, 2012) are discussed.

Let us now consider the key findings in relation to the first specific research question.

## **Rendering Children Knowable and Governable**

The first findings chapter focused on the knowledges and 'truths' that aim to render children governable and amenable to political programming. Apart from the general governmentality orientation, this part of the thesis draws from Fleck (1981) and his concepts that are aimed at analysing scientific knowledge from a sociological point of view. This chapter illustrates how numbers, being presented as 'objective truths', function to raise public concern about ADHD. In this context, Fleck's analytical tools proved to be particularly useful in analysing how knowledges are put together and altered in order to produce such 'truths', a process he termed 'sociocognitive migration of fragments' (Fleck, 1979, p. 118).

From a governmentality perspective, the findings highlight the key role the supposed prevalence rate of ADHD plays in legitimising current practices of the 'regime of truth' around ADHD, including the mass drugging of children. In the light of epidemiologic rationalities, numeric 'truths' function here to predict the percentage of the population of children in Switzerland that is believed to have 'ADHD'. The idea of a fixed prevalence rate that is popularised throughout the discourse resonates with research that presents ADHD as a primarily biological entity (cf. Polanczyk et al., 2007). However, the analysis also identifies counter-discourse texts that question the discursively established 'truth' of the prevalence rate, for instance by highlighting how the structural characteristics of the Swiss education system seem to influence practices of identification and treatment of ADHD in children. These findings resonate with previous research. For instance, Timimi (2005) argued that changes in the education system drive diagnoses.

In a similar vein, Armstrong (2006) suggested that immaturity in the youngest children of a school class may attract diagnoses, while Haubl and Liebsch (2010b) proposed that, in the light of scholarly demands, the label 'ADHD' and the pharmaceutical treatment it attracts may be used as a means of human enhancement. Moreover, in line with Timimi and Maitra (2009), this research illustrates that cultural differences (in the context of this thesis, across regions in Switzerland) seem to significantly shape diagnostic and treatment practices and that 'symptoms' of ADHD are highly culturally constructed entities (Mann et al., 1992; Sonuga-Barke et al., 1993). Beyond supporting these earlier findings, this research has added to the existing body of knowledge by illuminating the ways in which the idea of a fixed prevalence rate endows 'experts' with both credibility and legitimacy, while simultaneously marginalising opposing views and at the same time rendering epidemiological rationalities into 'self-fulfilling prophecies'.

The analysis, again drawing from Fleck (1979), further illustrates how recommendations of the *German Guideline on ADHD* (DGKJP et al., 2018a, hereafter *Guideline*) regarding diagnostic processes and treatment interventions are based on vade mecum science rather than journal science. This again reflects previous research. For example, Wastell and White (2017, p. 27) suggest that such knowledges aim to produce 'take-away knowledge' that is 'self-evidently right'. In addition, the analysis of the *Guideline* has added to the existing body of literature in terms of insights into how recommendations are predominantly based on consensus regarding 'best clinical practice' without reference to research. While the *Guideline* seems to fail in fulfilling its own claims to a 'scientific base', the findings suggest that what it indeed demonstrates is the power of professions to define their own professional practice. Furthermore, in promoting pharmaceutical treatment for ever younger children, and more comprehensively, i.e. in cases of less severity, the *Guideline* resonates with the biological reductionism found in much of the medical research around ADHD (see, inter alia, Barkley, 2002; Biederman, 2005; Faraone et al., 2015). Yet the examination of critical accounts suggests that the treatment of children with psychotropic drugs is

one of the biggest controversies in the discourse on ADHD. Such counter-discourse supports previous critical research that challenges the claim to the usefulness of drugging children (e.g. Storebø et al., 2015) and, more generally, the obsession with the 'early years' of children's development (Wastell and White, 2017).

This thesis suggests that the knowledges around ADHD, including the claim to epidemiology and the suggestions regarding diagnosis and treatment, are entangled with power. Here, the analytical tools of Foucault (2002, 1991b, 1989) have been useful in analysing how the 'regime of truth' around ADHD in Switzerland establishes discursive limits that define what is legitimately sayable about ADHD. More specifically, the findings illustrate how members of the counter-discourse are marginalised through aligning them with 'anti-psychiatry', which resonates with previous research. For instance, Double has argued that mainstream psychiatry generally tends to assign the label of anti-psychiatry 'to criticism which it does not accept' (2019, p. 61). This research further illustrates the central role that key opinion leaders play in aligning the interests of the pharmaceutical industry with those of other significant actors, including the parents' advocacy association Elpos. Moreover, the results suggest that despite its claims to neutrality and objectivity, Elpos is significantly shaped by the work of key opinion leaders (with some gathering under the umbrella of the Swiss Society for ADHD). This is consistent with previous research regarding the significance of key opinion leaders in shaping psychiatric discourses (Jackson, 2009; Moynihan, 2008; Rose, 2019). Also, these findings resonate with work regarding the central drivers of the popularisation of ADHD. For instance, Conrad and Bergey (2014) have suggested that advocacy groups and the Internet play significant roles in the dissemination of the medical model of ADHD and its treatment with pharmaceutical drugs, while Abraham (2010) emphasises the influence of the pharmaceutical industry in these matters.

In contrast to findings regarding the discourse on childhood ADHD in France (Ponnou and Gonon, 2017), social workers are almost completely absent

from the discourse in Switzerland. This may reflect the tendency of certain countries, including France and Italy (both sharing borders with Switzerland), to 'perceive ADHD as a psycho-affective disorder' and to favour 'psycho-social interventions' over drugs to treat children (Conrad and Bergey, 2014, p. 34). The focus lies on elucidating the meaning of symptoms and their connections to the environmental circumstances that affect children's behaviour and wellbeing, which, arguably, resonates much more with social work norms and values. However, this hypothesis would need to be tested in the light of further research. Moreover, the views of those rendered problematic, i.e. the children themselves, are equally absent from the discourse in Switzerland, just as they are in other geographical regions (see, *inter alia*, Harwood et al., 2017; Ponnou and Gonon, 2017).

Over and above supporting these findings, this thesis has added to the body of knowledge by showing how the pharmaceutical industry has found more subtle ways to market its drugs. For instance, while direct-to-consumer advertising of psychotropic drugs is not allowed in Switzerland, Novartis has published a children's book that aims to educate children on the usefulness of taking pills in the face of 'ADHD' (cf. Albrecht, 2001). Additionally, while Elpos itself does not receive funds from the pharmaceutical industry, they organise joint conferences with the Swiss Society for ADHD, which is partially funded by several pharmaceutical companies (cf. SFG ADHS, 2018b). In conclusion, the first findings chapter illustrated how children are rendered knowable within relations of power and knowledge that significantly limit what is sayable about ADHD. Let us now consider how children, based on these knowledges, are then conceptualised and represented in the discourse on childhood ADHD.

## **Conceptualising and Representing Children**

The second findings chapter elaborated upon how children are conceptualised and represented in the discourse on childhood ADHD in Switzerland. The findings indicate that the concept of ADHD is being established along (visual) representations of the deviant, the distressed and



the self-regulating child. Furthermore, the majority of visual representations depict white, pre-adolescent boys of a middle-class background. This supports earlier work. For instance, Schmitz et al. (2003) suggested that while these images establish the 'typical ADHD child', they do not account for diversity in terms of class, gender, age and 'race' in those labelled with ADHD. While further research would be needed regarding the specific context of Switzerland, it may be argued that these depictions are likely to fail similarly in acknowledging diversity.

Combining governmentality with concepts of the new social studies of childhood, the second findings chapter drew on the images proposed by Jenks (2005) and further developed by Smith (2012). These images were particularly useful in tracing the move from the 'bad' (i.e. Dionysian) to the 'ill' (i.e. Apollonian) child, and to account for the more recent shift towards an idealised image of advanced liberal subjectivity, the Athenian child.

More specifically, references to deviance in children appear frequently in the discourse. In visual representations children's behaviour is depicted as inappropriate in various situations e.g. while having a tantrum, fidgeting around or not paying attention in situations of homework and schoolwork. The image of the deviant child is further built through ascriptions of a number of labels. While these labels are reminiscent of the discourses of the 'evil child' as represented by the Dionysian image of childhood (cf. Jenks, 2005), the emphasis lies on the pathology of their behaviour. In other words, through pathologisation, in which labelling plays an important part, children are rendered 'ill' as opposed to 'bad', which reflects conceptualisations of the Apollonian (and, more recently, Athenian) child. Consequently, children are subjected to medical treatment rather than punishment. The results further illustrate that the concern with children's deviant behaviour is less with their current presentation but more with their future outcome. Against an idealised image of the Athenian child deviant behaviour is considered risky and a sign of serious troubles to come. This resonates with previous research. For instance, Donzelot (1980) and, more recently, Jenks (2005) traced the shift

from 'bad' to 'ill' in the conceptualisation of children. Moreover, the concern with 'risk' resonates with the work of Beck (1992) who suggests that, in the wake of post-industrialisation, private lives are dominated by concerns about risks and that this is exaggerated by considering risks as located in the individual (child) rather than in societal structures. In addition, the work of Tulloch and Lupton (2003) suggests that the avoidance of risky behaviour (which arguably includes most behaviours described as indicative of 'ADHD') is increasingly considered as representative of a 'civilised body', while Bailey (2010) argues that ADHD is basically a means of identifying and labelling the 'dangerous child'. This is consistent with previous work that suggests that such identification and labelling processes carry a 'worrying number of negative identities for children' (Horton-Salway, 2018, p. 92) and adds to that body of knowledge an elaboration of a wide range of potentially stigmatising labels.

Furthermore, the idea of being the 'ill' rather than the 'bad' child is further substantiated by emphasising the distress experienced by children labelled with 'ADHD'. Visual representations transported on the media plane depict children as trying hard to conform to an idealised advanced liberal subjectivity (i.e. the Athenian image of childhood) but being unable to do so. I have argued that such representations are not neutral but aim to raise concern through the use of particularly convincing stories. This supports earlier findings of Best (2001, p. 56) who suggests that such 'vivid examples' presented on the media plane tend to be 'especially dramatic'.

The results further illuminate how distress serves to legitimise psychotropic interventions, which are presented as a moral obligation to alleviate distress. This research adds to the body of knowledge in that it illuminates how distress has become a paramount decisive element in the discourse on childhood ADHD in Switzerland, legitimising pharmaceutical interventions even in the absence of a psychiatric diagnosis.

Moreover, the findings illustrate that while deviance and distress are constitutive elements of the pathologic child, a further image is being

presented. In what has been theorised as the Athenian image of childhood (cf. Smith, 2012), a number of behavioural ideals are promoted throughout the discourse, including self-regulation, flexibility, time management and reflection. This is most visible in the emphasis on 'executive functions', which aim to rationalise deviations from the idea of the self-governing subject of advanced liberal rule (Dean, 2010; Rose, 1999; Smith, 2012). This is in line with the wider cognitive research strand of the hegemonic biological discourse that suggests that differences in the brain structure of children labelled with 'ADHD' negatively affect executive functions (Barkley, 2014). In addition, previous research has suggested that these differences in turn lead to discredited behaviour in children in environments where there is a strong emphasis on sedentary behaviour (Lloyd et al., 2006a).

The findings further highlight a certain emphasis on 'self-regulation', which includes the ability of children to align their choices with an idealised image of the Athenian child. For instance, children are required to dedicate themselves to activities they may perceive as completely void of meaning, particularly in scholastic environments (see, *inter alia*, Czerny, 2010; Robischon, 2019). Against this backdrop a primary aim of 'ADHD' therapy seems to be to adapt children to that void.

This reflects previous research. For instance, Tait (2006) emphasised how governing in contemporary discourse is ultimately founded upon self-governance, while Cooper (2001) suggested that, in line with this idea (of self-governance), children are increasingly being held accountable for making the 'right' choices. In agreement with earlier work of Smith (2012), this research suggests that, while in the light of the Apollonian image of childhood poor performance has been considered as maladjustment, in the contemporary discourse the concern lies rather with responsibility. The findings add to the existing body of knowledge by illuminating how the idea of the Athenian child is built around idealised behaviours that are promoted throughout the discourse, on multiple planes.

In conclusion, I have argued that children are conceptualised and represented in the discourse on ADHD along the line of depictions of deviance, distress and self-governance. The next section draws together the findings in response to the question of how children are governed towards specific ends, by building upon the knowledges and images discussed above.

## **Governing Children towards Specific Ends**

The third findings chapter elaborated upon how children are governed towards specific ends. It illustrated that children labelled with 'ADHD' tend to resist routine tasks, such as monotonous schoolwork. This resonates with previous research that suggests that teachers have been confronted with children either unwilling or unable to subject themselves to scholastic discipline ever since the introduction of compulsory education (Donzelot, 1980). In line with previous research (DuPaul and Eckert, 1997; Hjärne, 2006), this thesis further illustrates how teachers are advised to impose even stricter rules on children who tend to resist disciplinary routines of mass education. In this context the work of Foucault on the 'instrumental coding of the body' (1989, p. 153) proved to be particularly useful.

The results further suggest that structural characteristics of the school, such as the recruitment of children into pre-schools at an ever-younger age, transitions (e.g. from pre-school to school), and the ideology of inclusive education drive both diagnoses and treatment of children labelled with a range of 'special educational needs', including 'ADHD'. This resonates with findings of previous research. For instance, Armstrong (2006) argued that young children in a class are particularly vulnerable to the pathologisation of immaturity, while Langberg et al. (2008) argued that environmental changes associated with transitioning to middle school coincide with an increase in symptoms that have been ascribed to 'ADHD'. Particularly useful in the analysis of such structural conditions has been the concept of structural violence as proposed by Galtung (1969). More specifically, it has facilitated the elaboration regarding how school may produce avoidable impairment

through the structural characteristics mentioned above. This thesis adds to the existing literature in that it demonstrates how the effects of structural conditions in schools are reflected in prescription practices of childhood ADHD in Switzerland.

Furthermore, the third findings chapter illustrated that such diagnostic and treatment interventions are presented as a means of helping children labelled with 'ADHD'. However, in line with previous research (e.g. Diller, 2009), the analysis also identified counter-discourse that are more critical about pharmaceutical interventions and portray them as a form of punishment. This echoes previous research about the tutelary complex (cf. Rose, 1999) and the dilemma of the 'double mandate' (Meinhold, 2005) that social work practice involves, emphasising that all attempts to help and care also contain elements of control.

In addition, the results illustrate that while much of the discourse on childhood ADHD in Switzerland focuses on problematising children's behaviour in relation to scholastic demands, depictions of the familial setting are much less common. Exemptions include the role of the family in relation to homework, and the role of parenting in relation to diagnostic and therapeutic interventions. In line with previous research (Smith and Barker, 2001), this thesis suggests that the boundaries between school and family are increasingly being blurred. For instance, the instrument of homework allows the extending of the medical gaze and panoptic surveillance into the sphere of the private home. Such governance increasingly incorporates the administration of psychotropic drugs to children and the recruitment of parents, particularly mothers, as allies in the assessment and management of 'mental health' in their children. In this context the analysis of the counter-discourse suggests that there are increasing signs of pressure put on children and on parents to assess and drug their children. This supports concerns raised by the United Nations Committee on the Rights of the Child 'regarding children being threatened with expulsion from school if their parents do not accept treatment of the children with psychostimulant drugs'

(2015, p. 14). This thesis adds to the body of knowledge by confirming that recent discursive shifts around education may increase the pressure on parents to assess and drug their children. For instance, it illuminates the ways in which the Cantonal Parliament of Basel-Country (2018) seeks to enforce diagnostic assessments of children, even in the absence of consent by their natural parents or legal guardians.

The results further illustrate that 'expert' discourse aims to move the blame for behaviour displayed in children labelled with 'ADHD' from the mother to the 'brain', which is consistent with previous findings. For instance, Reid and Maag (1997) suggest that ADHD offers a 'label of forgiveness' while, more recently, Singh (2004) argues that in the light of such a 'no-fault model of behaviour', no-one can be held responsible for behaviour that grows out of disorder. Yet the analysis of the counter-discourse supports the claim of Timimi that such labels 'never solv[e] the nagging doubt in the back of a parent's mind that it is their fault' (2006, p. 206).

This research has further illustrated how children's leisure time is increasingly aligned with educational goals. In line with previous research (cf. Miller and Kuhaneck, 2008), the results suggest that through focusing on its educational value, the tutelary complex regards 'play' both as an indicator of child development and as a (therapeutic) means of intervention. For instance, chess is being employed as a means to govern children towards the idealised image of the Athenian child. This reflects the earlier work of Rose who suggests that such (therapeutic) approaches are regarded as a means of enabling children to invest into their 'emancipatory project of learning to be a self' (1999, p. 242), and supports the idea from earlier research that discursive practices around ADHD increasingly mesh leisure and therapy. For instance, Montgomery (2009) argues that, in the wake of such practices, it has become difficult to draw a distinction between play, education and socialisation.

Moreover, the findings suggest that the idea of 'free time' tends to disappear in favour of more 'constructive' activities, which in turn leads to an increase in

the institutionalisation of children's leisure time. This is in line with previous research. For instance, Montandon (2001) found that more than one third of the children who attend the Swiss public education system were also enrolled in various extra-curricular activities organised by the school, while Ennew (1994) suggested that children's lives were increasingly being timetabled beyond the spatial and temporal confinements of the school. This thesis adds to the body of knowledge by indicating how such discursive shifts are again shaped by power/knowledge relations along the lines of societal categories of experience, including gender and class.

In conclusion, it is evident that children are governed towards specific ends through the precise spatial and temporal organisation of social spaces (i.e. the school, the family and leisure), which includes a number of technologies (such as homework and pharmaceuticals), and are based upon the knowledges and idealised images of childhood discussed above.

Building on these main findings, the next section aims to take the discussion further and to derive some practical implications for social work.

## **Implications for Social Work**

Each chapter has focused on a particular topic, adopting a governmentality perspective and drawing from further theoretical concepts to analyse the discourse on childhood ADHD in Switzerland. Although each chapter has taken a different angle, there are important links between the findings. The next paragraphs offer some introductory considerations regarding the challenge of aligning social work practice in (minority world) mental health systems with social work values. I then go on to draw together insights from across the three analytical chapters. These insights point to four implications for practice that I believe social workers, and any other practitioners working with or for children, should be aware of.

## Introduction

Aligning social work practice regarding diagnostic processes in emotional, mental and behaviour disorders with social work values designates a challenge (Corcoran and Walsh, 2016). Critiques have emerged from social work and related professions on both diagnosis and treatment in mental health (Raines, 2014). They include a problematisation of coercion in psychiatric treatments, the unscientific nature of the DSM and its control of the distribution of services, the DSM's lack of emphasis on environmental influences on human behaviour, and the failure of drug treatments to improve mental health outcomes (Kirk et al., 2015). The disease model of abnormality underlying the DSM emphasises the individuality of problems and asks for changes within the person, which causes tensions with the environmental approach of social work (Corcoran and Walsh, 2016). Adopting a biopsychosocial perspective, Wachs (2000) argues for a much broader understanding of behaviour in children, emphasising the role of the child's immediate and wider environments, such as adverse parenting style, social deprivation and poverty.

Although social workers tend not to classify individuals as 'abnormal' or 'disordered', they are often asked to do so in order to receive reimbursement for services they deliver (Corcoran and Walsh, 2016). In the US, clinical social workers constitute more than half of the mental health workforce, amounting to more than 100,000 professionals (Raines, 2014). By contrast, there are only 33,000 psychiatrists. Nevertheless, the role of social work in the drafting of the latest revision of the DSM has been minimal. Among the 13 DSM-5 committees, there was only one social worker, as opposed to 97 psychiatrists (ibid., p. 2). The discontinuation of the multi-axial system in the DSM suggests that the social work perspective has been marginalised. As Raines puts it,

[a]xis IV offered the only opportunity to discuss psychosocial or environmental factors that caused or contributed to a mental disorder, and Axis V the only opportunity to identify strengths (functioning) of the individual being



diagnosed. Without these two axes, the DSM-5 reverts to a biologically driven, deficitbased model of mental illness (2014, p. 2)

This biological reductionism was criticised in an open letter to the DSM-5 Task Force by the Society for Humanistic Psychology (2011). The letter received official support from 53 professional associations but the National Association of Social Workers decided not to endorse it (NASW, 2012). NASW seems to adopt a medicalised perspective in its approach to mental health, as becomes evident in its online information on ADHD (2005).

Social work has been criticised in the literature for its increasing tendency towards medicalised interventions (Levine, 2000) and for reducing its role to facilitating medication adherence (Jensen, 2004). Though written from a social work perspective, some accounts label children as being 'dysfunctional' (see, for example, Segal, 2001). Despite efforts to incorporate a strengths-based orientation and an appreciation for environmental influences, the pathology-oriented medical model remains the dominant framework in social work practice (Gingerich and Wabeke, 2001). Adopting a categorical rather than a dimensional approach (Bailey, 2013) facilitates social workers with the means to differentiate 'ADHD children' from 'normal children' (Segal, 2001). A more sophisticated differential diagnosis (Desgranges et al., 1995), however, would enable social workers to include environmental aspects affecting the cause, maintenance and treatment of 'ADHD', to elaborate on the role of parenting (Howe, 2010), and to acknowledge that parents are often victims of intergenerational cycles of neglect themselves (Pritchard, 2015). Although the discourses in schools tend to reflect the medical model of ADHD and thus are at times hostile to traditional social work values (Levine, 1997), school mental health literature identifies school social workers as key players in addressing behavioural problems in children (Diaz, 2015). School social workers are hence encouraged to collaborate and consult with teachers (Gingerich and Wabeke, 2001) and to play an important role in integrating systems such as the family and the school into the elaboration of an individual child's life-world (Thiersch, 2008). Research has indicated that the intensive involvement of a

social worker may significantly reduce behavioural problems in children and their use of pharmaceuticals (Cohen, 2006b).

After these introductory considerations, let us now turn to four implications for practice that I have derived from the findings of this thesis.

## **The Social Construction of Health and Illness**

This thesis supports the wider sociological literature that suggests that illness (and indeed health) are social constructions (see, *inter alia*, Illich, 1977; Zola, 1977). As opposed to a medical ‘disease’ (where the aetiology is known and an objective physical condition can be demonstrated), a psychiatric ‘illness’ describes a ‘subjective distress’ with no demonstrable underlying physical condition (Katona et al., 2015, p. 6). In other words, psychiatric diagnoses, such as ‘ADHD’, are built completely on hypotheses, such as the idea of an imbalance in brain chemistry.

More specifically, this thesis illustrates how the definition of ‘symptoms’ (as constitutive elements of ‘psychiatric diagnoses’) is not based on science but on decisions that are likely shaped by social, cultural and economic factors. For instance, the number of tantrums per week that a child needs to display to qualify for the diagnosis of Disruptive Mood Dysregulation Disorder (cf. APA, 2013) has discursively been set to three. As discussed before, a child psychiatrist and consultant of the Swiss Federal Office of Public Health admits in a newspaper article that what is considered ‘illness’ and, in this context, the number of tantrums required as a threshold for a diagnosis, is ‘arbitrary in its tendency’, and constitutes ‘not a scientific, but a political decision’ (Schmid, 2013).

In a similar vein, the foundation of ‘ADHD’ as a ‘behavioural disorder’ lies in the description of a plethora of ‘deviant behaviours’. Here, normalisation processes become particularly apparent, as not only being too outgoing (which is rendered problematic and labelled as ‘hyperactivity’) is considered pathological, but also being not outgoing enough (which is rendered equally problematic and labelled as ‘daydreaming’).

In addition, this thesis indicates that these 'symptoms' are understood differently across cultural regions in Switzerland, which highlights how 'deviant behaviour' is at least in part shaped through cultural understandings. The analysis of the aetiological basis of ADHD further suggests that vague assumptions are translated into 'scientific facts' (Fleck, 1979). Such processes of translation are not neutral but informed by particular knowledges that are entangled with power. Arguably, in the context of Switzerland, the single most important vehicle for the popularisation of the concept of childhood ADHD is the claim to its prevalence rate. As suggested earlier in this thesis, such epidemiological rationalities are used to legitimate the pathologisation and drugging of children at the level of populations. This supports Inda's argument that 'the principal target of government is population', which includes to 'act upon the particulars of human conduct' in order to increase 'the security, longevity, health, prosperity, and happiness of populations' (Inda, 2005, p. 6). However, this thesis argues that the claimed (global) prevalence rate of five per cent has been created through statistical manipulations that are based on debatable assumptions and specific knowledges that are entangled with power.

Furthermore, this thesis suggests that the social meaning attributed to 'deviant behaviour' is understood in the light of changing conceptualisations of childhood, including the Dionysian, Apollonian and Athenian images (cf. Jenks, 2005; Smith, 2012). Such images significantly inform the way we rationalise children and how we respond to their behaviour. These images have changed in the past and are likely to change in the future.

While (Piagetian) notions of development clearly contribute to the understanding of members of the tutelary complex, including social workers, of how children grow up, they tend to marginalise or even ignore social and environmental explanations. The current hegemonic discourse therefore tends to reduce children labelled with ADHD almost entirely to biological dispositions and processes, and potentially mutes children (and their families) by subjecting them to standardised (medical) regimes. This thesis

suggests that the way we construct health and illness and, more generally, childhood, has real consequences for children. While the move from psychoanalysis to pharmacology has shifted the blame to the 'brain' and re-conceptualised children from being 'bad' to being 'ill', suppressive forms of governing their lives seem to persist.

## **The Entanglement of Power and Knowledge**

This thesis indicates that throughout the hegemonic discourse around childhood ADHD in Switzerland some voices are supported while others tend to become marginalised or even suppressed. Practitioners working for and with children, including social workers, should be aware that those empowered to make claims about ADHD, its significance and its treatment are likely to have a vested interest. As Clapton and Cree (2017, p. 71) suggest in their research on childcare charities in the UK, the way claims to 'truth' are being presented in the media may have 'damaging consequences for social work with children and families and for society as a whole'. Presenting certain individuals and behaviours as 'risky' and linking them to 'bad' outcomes, they further suggest, may contribute to societal and professional reactions that are disproportionate and frame children's needs in unhelpful ways.

More specifically, this thesis suggests that the parent advocacy association Elpos, which depicts itself as a neutral and independent 'association of concerned parents', both shapes and is significantly shaped by the hegemonic discourse on ADHD. Elpos is well known for its awareness-raising campaigns that are addressed to the general public, authorities, professionals and teachers (Ehrat, 1994). Through its reputation as an independent and objective organisation in relation to ADHD, Elpos has arguably become an important port of call not only for parents but also for the wider 'tutelary complex' (Donzelot, 1980), including social workers.

Adopting a critical perspective, this thesis suggests that the knowledges Elpos is both drawing upon and disseminating are not neutral but entangled

with relations of power (cf. Foucault, 1989, 1980). For instance, in 1995 Elpos amended its organisational structure in order to receive funding from the Swiss Federal Social Insurance Office. Being funded by a governmental body does not necessarily undermine Elpos' claim to objectivity but arguably it renders its claim to independence questionable.

Moreover, this thesis problematises Elpos' close collaboration with key opinion leaders in the field. This relationship appears to be mutually constitutive. While key opinion leaders are invited to publish their articles with Elpos, they in turn contribute to the popularisation of the parents' advocacy organisation and endorse it with authority and legitimacy. The findings illustrate that the knowledges Elpos is both drawing upon and circulating are in support of the mainstream discourse and consequently generally in favour of the current 'thought style' (Fleck, 1979) that emphasises biological reductionism and pharmaceutical interventions.

Moreover, through its close collaboration with the Swiss Society for ADHD (hereafter Society), Elpos is arguably vulnerable to the influence of the pharmaceutical industry. For instance, key opinion leaders who closely collaborate with Elpos and who are members of the Society have repeatedly declared substantial ties with the pharmaceutical industry. While the Society, as opposed to Elpos, is directly funded by this industry, the close collaboration of both organisations (including joint conferences and joint publication of articles) arguably renders both organisations vulnerable to political programming.

While this is not necessarily problematic per se, it should nevertheless form part of an overall critical assessment of claims to 'truth' made by Elpos and the Society. Such a critical reflection on the knowledges around ADHD may include elaborating upon the sources that these claims are built upon, to examine why particular people have been given a voice and to scrutinise why they have been quoted in certain contexts. Such a critical approach may include examining possible links to other individuals and organisations, possible conflicts of interest arising out of these links, and the particular

expertise these individuals and organisations draw upon. This thesis indicates that the hegemonic discourse on childhood ADHD in Switzerland is driven by ‘experts’ who seek to bring to the fore specific kinds of definitions, evidence and meanings, while simultaneously marginalising the bodies of knowledge that confront these. Acknowledging these relations of power and knowledge would enable social workers to identify practices that are potentially disempowering and stigmatising.

### **The Emphasis on Distress and the Marginalisation of Context**

As discussed in the second findings chapter, representations of distress are a core element along which childhood ADHD in Switzerland is discursively constructed. Since ‘mental illness’, as opposed to a ‘medical disease’, has no demonstrable underlying physical pathology, the idea of subjective distress is employed to legitimise both labelling processes and treatment interventions in children. This is particularly visible in the stories presented throughout the discourse. In line with Best (2001), I argue that such illustrations are usually particularly dramatic and compelling. For instance, they contain descriptions of boys jumping on classmates and biting them in the neck (Daum, 2005) or throwing a tantrum at school and slapping other students (Jeitziner, 2005). Such stories do not represent the wider population of those labelled with ‘ADHD’ but rather aim to depict the significant burden this ‘mental ill health’ may bring. The focus is on ‘illness’ rather than ‘badness’ in these children and the relief that pharmaceuticals bring. Without discrediting the significant distress individual children experience, it may be argued here that such examples are not at all representative. Rather, they are aimed at emphasising the moral obligation to alleviate suffering. In doing so, these representations serve as a means of legitimating pharmaceutical interventions, even in the absence of a diagnosis:

[o]f course, ADHD-specific treatment can also be carried out in cases of high levels of distress even if there is no confirmed ADHD (Rossi, 2016a, p. 17)

Although I in no way seek to relativize or deny the distress experienced by many children, I suggest that while distress in children is real, the way we

frame and address it seems unhelpful. As Wastell and White (2017, p. 74) emphasise, viewing ADHD in solely neurological and genetic terms 'fundamentally changes the manner in which we think about, and explain, human life'. This, they further suggest, also shapes research agendas, particularly in terms of what priorities are defined and how funds are allocated. Arguably, such an approach tends to mask environmental aspects shaping behavioural patterns and, in turn, potentially leads to disempowerment of children. As mentioned in the literature review, research conducted in Switzerland (and beyond, see Haubl and Liebsch, 2010a) suggests that children themselves tend to be much more critical regarding the usefulness of stimulant therapy than the members of the 'tutelary complex', in which social work plays an important role (Esslinger and Schöbi, 2017). Regarding the question of whether ADHD medication has an influence on their distress, only 30% of the children answered 'my distress decreases', while 15% said 'my distress increases', 45% said it has 'no influence', and 20% chose to not answer the question.

This raises significant ethical questions about self-determination, which also resonate with concerns raised by the Swiss National Advisory Commission on Biomedical Ethics (NEK-CNE, 2011). In this context, children who resist or do not respond as expected to stimulant treatment may be subjected to even more extensive treatment regimes, involving a combination of pharmaceutical agents. For instance, a counter-discourse account problematised that a boy aged 10 was subjected to methylphenidate in the morning, antidepressants at noon and a sleeping pill in the evening (Straumann, 2015b). In addition, this thesis suggests that non-compliance to such regimes in children may put a lot of pressure on parents. As I have illustrated, against this backdrop the role of social workers in this context is potentially seen as that of 'compliance manager' (Janzen and Jeffery, 2013). However, reducing social work to that role may further disempower children and disregard non-medical explanations of resistance, such as cultural differences. An indicator of the rather weak status of children in the discourse on ADHD in Switzerland is

their almost complete absence on all discourse planes analysed (i.e. the media, the political and the parental advocacy planes).

However, recognising the importance of social and environmental contexts to development in children may not necessarily lead to more sensitive and empowering approaches. Critical scholars have repeatedly argued that while more recent conceptualisations of childhood indeed recognise the active role of children in their own development, they may also lead to the extension of the 'gaze' into both intra- and inter-personal aspects of children's life-worlds (cf. Fendler, 2001; Smith, 2012).

Furthermore, framing individual distress in solely medical terms may both reinforce and obscure larger inequalities in society, including those based on 'race', gender and class. Through the narrow understanding of behaviour displayed and level of distress experienced, early intervention and preventive strategies, of which social work is part, may risk unnecessarily drawing children into therapeutic regimes.

Arguably, larger social inequalities significantly affect the way we approach, diagnose and treat children whose behaviour has been considered as signs of ADHD. For example, Hart & Benassaya suggest that there is a strong relation between class and ADHD prevalence, with 'low prevalence at the top, and high prevalence at the bottom of the social hierarchy' (2009, p. 229ff). In a similar vein, Hjern et al. (2010) argues that social adversities in families, including lone parenthood, low maternal education, and reception of social welfare, are also linked with higher levels of medicalisation in children. However, such inequities are strikingly absent in the data, suggesting that these forms of societal structural violence (Galtung, 1969) are largely obscured.

Furthermore, rather than mitigating such inequalities, modern education tends to reinforce them. As I have discussed in the literature review, contemporary education tends to reproduce social inequalities, leading to social injustice (cf. **Education and Structural Violence**, p.14). This seems



to be particularly relevant for children labelled with ADHD. It is the role of education the discussion of implications now turns to.

## **The Role of Mass Education**

The analysis of the discourse on childhood ADHD in Switzerland suggests that environmental factors significantly shape the lived experiences of children, and that these factors are potentially masked through framing ADHD solely or even primarily in medical terms. In particular, findings suggest that the specific spatial and temporal characteristics of contemporary mass schooling may undermine the healthy learning journeys of many children, rather than enabling them.

For instance, recent shifts in educational policy in Switzerland (cf. EDK, 2015) require children to sit still and focus at an ever earlier age. What used to be a kindergarten has now been re-conceptualised as pre-school. This includes the adaptation of some spatial and temporal characteristics of the school, such as the idea of subjecting four-year-old children to standardised units of time, i.e. 45 minute long lessons. Accounts from paediatricians indicate that such requirements may drive diagnoses and assessment in children and that 'children are pathologised because there is a lack of knowledge in schools' (Schmid, 2011). While children in Switzerland are recruited at age 4, the school leaving age is still 15 (Educa, 2020), which means that children are at school for longer than ever in history.

Moreover, transitions such as from pre-school to school, and from primary school to secondary school, seem to put children under stress. Increases in stimulant use during these times of transition, i.e. at age 6 and age 12 (Hirschberg, 2011) suggest that such structural violence (Galtung, 1969) provokes distress in children, which is then sought to be alleviated through pharmaceutical means. Additionally, political debates indicate that the school may be a source of pressure in the pathologisation of children. For instance, as I mentioned in the third empirical chapter, a recent motion presented to the Cantonal Parliament of Basel-Country (2018) proposes to enforce

diagnostic assessment in children even in the absence of consent by their natural parents or legal guardians if either the development of the child would be at risk or if the school environment would be significantly affected.

As Heinz (2015) suggests, there is a potential danger in interpreting socially undesirable behaviour as a symptom of an illness. The reference to the school environment that would be negatively affected if the child is not subjected to medical intervention seems to substantiate this concern. In other words, if a child is considered a burden to his or her (school) environment, then they should be subjected to medical intervention. In the wake of the abolishment of corporal punishment in schools, subjecting children to pharmaceutical treatment may also be regarded as a form of punishment, blurring the boundaries between discipline and treatment. The findings suggest that if children resist the inscription of routines into their bodies, then they are subjected to even closer supervision and management. For instance, a detailed account of how to increase children's compliance with the routines of homework presented by two psychologists (Grolimund and Rietzler, 2016) is reminiscent of what Foucault (1989, p. 153) termed the 'instrumental coding of the body'.

Furthermore, contemporary mass education seems to fail many children in terms of offering them a meaningful learning environment. Particularly, the approach of cutting down the learning processes into very small steps and standardising these steps in terms of spatiality and temporality seems to potentially strip contemporary educational practices from meaning. This is particularly visible in the following account of a psychologist who argues that

[o]ne of the main goals of any ADHD therapy is the ability to dedicate oneself to something that is not so interesting subjectively. If a child with ADHD has a reasonably good command of this, [they] can listen to a teacher even if it sounds less interesting, can stick to [their] homework, even if [they] do not see any sense in it personally... (Rossi, 2016b, p. 50)

In other words, children are subjected to a learning environment that may be boring and completely void of any meaning to them. As Paul Willis (1977) demonstrated in his seminal ethnography on white working-class boys, mass

education fails these children in terms of social mobility. While schools tended to prepare working-class boys to become factory workers, the follow-up work, *Learning to Labor in New Times* (Dolby et al., 2004), emphasised that more recently they prepare these children for precarity and unemployment.

However, if children react in undesirable ways to this loss of meaning in their learning journey, then this (i.e. their behaviour) becomes pathologised. As I have argued earlier, the main aim of 'ADHD' therapy, thus, seems to be to adapt children to the void. The requirement of a child being able to 'stick to [their] homework, even if [they] do not see any sense in it personally' has been operationalised by the DSM. Accordingly, a child with 'ADHD' is considered one who '[o]ften avoids, dislikes, or is reluctant to engage in tasks' that are potentially meaningless to them, including schoolwork or homework (APA, 2013, p. 59).

While there is a clear emphasis on normalisation, the individual needs and interests of children seem to be largely unaddressed. Particularly, children with a high level of creativity and divergent thinking seem to develop distress in such environments. The findings of this thesis support earlier accounts of critical educators that have repeatedly pointed to the necessity of making education more meaningful (see, for example, Czerny, 2010; Robischon, 2019).

The visual analysis of pictorial representations used in the discourse on ADHD in Switzerland suggests that the school plays a pivotal role in building the image of the 'ADHD child'. Without the institutional setting of the school, much if not all behaviour problematised under the umbrella 'ADHD' that I discuss in the second findings chapter becomes meaningless. This resonates with previous research. For instance, Gerspach (2006) argues that ADHD can only be understood in the context of the school and its wider embeddedness in society.

I argue that the hegemonic approaches of the 'tutelary complex', including social work, that frame behaviour primarily in medical terms tend to render children pathologic and in need of interventions that aim to bind them to potentially harmful structures. As has been illustrated, both the construction of ADHD and the design of its related diagnostic processes are aligned with the requirements of modern mass education rather than with needs of children. Recent discursive shifts, such as the emphasis on inclusion in education (cf. Binswanger, 2013) and the alignment of family life (cf. Straumann, 2012) and leisure (cf. Zilic, 2011) with educational objectives, that I discuss in the third findings chapter, may further exacerbate the situation for children labelled with 'ADHD'. Against this backdrop, subjecting children to pharmaceutical intervention to align them with the temporal and spatial requirements of contemporary mass schooling does not appear to be a sensitive, empowering approach.

## **Conclusion**

The implications discussed above in relation to the social construction of health and illness, the entanglement of power and knowledge, the emphasis on distress and the role of mass education aim to sensitise social workers and the wider 'tutelary complex' more generally, that behaviours displayed in children may be framed and addressed in ways that potentially marginalise and pathologise children. Since social work is nearly completely absent from the discourse planes analysed (i.e. the media, political and parental advocacy planes), what may be said about practical applications for social work is limited. However, adopting a governmentality standpoint and linking it with theories of social work as proposed by Staub-Bernasconi (2011, 2007), the next section aims to offer some perspectives for social work.

## **Perspectives for Social Work**

The analysis of the discourse on childhood ADHD in Switzerland suggests that this phenomenon is constructed along specific knowledges that are entangled with power and that potentially reduce behaviour in children to the

biological dispositions of their brains. Yet counter-discourse suggests that such an approach does not account for the multitude of possible contributing factors that may lead children to act the way they do. The next paragraphs offer some introductory considerations regarding such complex social phenomena, (the role of) social work, specialist knowledge and professional status. I then go on to introduce possible perspectives for social work.

## **Introduction**

This thesis supports the wider sociological insights discussed in the literature review, suggesting that there is no one grand theory that can explain all deviance in children, and that conduct and deviance, as well as health and illness, are social constructions. Against this background, I argue that social work (and indeed the wider tutelary complex) needs to be open-minded regarding different explanations and approaches to address the complex phenomena we experience. There are certainly critical developments within the field, and the profession has shown significant efforts to professionalise itself throughout the last decades. These efforts have led to anti-expertocratic discourses, criticising social work practices that adopt the bio-medical model and accept unquestioningly the authority of medics (Hanses, 2007). For instance, an argument brought forward by critics was that while the introduction of the idea of 'diagnosis' may have a value in positioning social work in the wider field of professions, it potentially also naturalises and individualises social problems.

However, more recently social work has begun to advocate for those labelled 'ill' and to support them in challenging medical orthodoxy (cf. Cree, 2010). Simultaneously, social work continues to be a member of the tutelary complex, working in ancillary capacities in traditional health settings led by medics. While there have been moves within social work to confront the structural inequalities (some of which have been problematised throughout this thesis) shaping the lives of children and their families, its role remains shaped by contradictory mandates of care and control (cf. Meinhold, 2005).

Social work must lay claim to specialist knowledge and skills if it is to achieve the professional status that it needs in order to survive and thrive in this ever-professionalising world. I have argued that mental health, and ADHD in particular, demonstrates one of the sites where we can see social work's over-reliance on medical models whilst failing to fully address environmental and structural issues. Moreover, I have suggested that social work would benefit from greater engagement with more critical analyses of the knowledge and skills that it expounds.

Against this backdrop, I suggest that the introduction of a 'third mandate' (cf. Staub-Bernasconi, 2011, 2007) together with a praxeological, emancipatory and reflexive perspective (cf. Hanses, 2007) may lead to advancing social work towards anti-discriminatory and anti-oppressive practices. It is to this 'third mandate' and these perspectives that the discussion now attends.

### **Praxeological Perspective**

The first perspective concerns the praxeological aspects of social work interventions. Hanses (2007) suggests that social work requires a perspective regarding both the production as well as the effects of power in the settings in which it operates. Social work hence needs both scientific knowledge and practice-oriented models that enable it to sensitise itself regarding the practices of power in social spaces and institutions (see third findings chapter) shaping the life-worlds of children and the significance of knowledge and power (see first and second findings chapters) in this context. As I have indicated, discourses, including that on ADHD, seek to normalise children and their behaviour. A praxeological perspective would therefore include a critical appraisal of such normalisation processes and their effects on children.

Social work practice takes place in a field of competing interests. Of particular concern are tensions arising from what has been theorised as the 'double mandate' (Meinhold, 2005). This term aims to emphasise that social workers are not only mandated to 'help' children and their families (as well as

adults considered in need), but also to 'control' them. Historically, this double mandate dates back to the 18th century and has consequently been described as the first mandate of social work (Schmocker, 2006). Through a societal macro-perspective lens, this mandate determines the necessities of individuals in the light of prevailing social policy and following the logics of organisations in social welfare societies in the minority world. The assumption underlying the double mandate is that the 'functionality' of society depends on the capacity of individuals to adapt themselves to the conditions of modern society (cf. Bommers and Scherr, 1996). This understanding still significantly shapes social work practice. For instance, social security provision to families is made dependent on those receiving it subjecting themselves to various disciplinary measures, such as reporting themselves to the authorities and getting their children medically screened regularly. It is in this context that the 'help' we offer children labelled with 'ADHD' may also be perceived of as a form of social control.

In the 1950s, however, emancipatory civil rights movements began to advocate for a second mandate in social work, one that takes an individual micro-perspective to address basic and legitimate human claims (cf. Schmocker, 2006). This anthropologically and social-psychologically motivated mandate suggests that those affected by hardship, poverty or injustice know best what they need and how to overcome their situations. For instance, mothers rejecting the medical doctrine to get their children vaccinated were increasingly considered as individuals raising legitimate, human claims, rather than disobedient people who were unable to subject themselves to this form of 'help' (and the control that came with it). In the wake of the economic turnaround of the 1980s, though, this second mandate is increasingly being marginalised (ibid.).

To move social work practice beyond the dichotomy of care and control, Staub-Bernasconi (2011, 2007) suggests combining these perspectives, i.e. the bottom-up perspective of the individual and the top-down perspective of society. However, to prevent any of these perspectives becoming dominant,

she proposes introducing a third mandate (which she termed the 'triple mandate') to mediate potential tensions arising from the first two mandates. Rather than focusing on 'necessities' defined by societies or 'claims' raised by individuals, the triple mandate considers 'human needs' as the ultimate objective that all social work should be aimed at. From this perspective the role of social work is to contribute to the realisation of human and socially just structures through addressing social problems that arise from marginalised human needs. Consequently, from a social work perspective, the third mandate is considered paramount, followed by the second mandate and finally the first mandate. In other words, the traditional understanding of the double mandate of social work is considered only the third priority.

The triple mandate, as proposed by Staub-Bernasconi, is based on three constitutive components: (i) descriptive and explanatory knowledge of the social work profession, (ii) moral-philosophical knowledge, particularly professional codes of ethics and (iii) principles of human and social rights as a general basis of legitimacy, particularly human rights (based on the concept of human dignity) and social justice. Such moral-philosophical knowledge would include both global (IFSW, 2018) and local (see, for the Swiss context, AvenirSocial, 2010) codes of ethics. Moreover, the general basis of the legitimacy of social work would draw from human rights treaties, including the Universal Declaration of Human Rights (United Nations, 1948), and, in this particular context, the Convention on the Rights of the Child (UN General Assembly, 1989).

Taking these considerations further, Schmocker (2019) emphasises that the concepts of human dignity and social justice, as core elements of the triple mandate, have to be understood as relational rather than attributive in their nature. To understand human dignity relationally, Schmocker suggests, means to consider above all the quality of relationships between people needed to enable them to build sustainable communities. Dignity, thus, is not something that a person possesses or does not possess and that someone could give or take away. Additionally, Schmocker suggests understanding



social justice as a cooperative way of acting that is capable of changing unfavourable social structures (ibid.).

Hence, the introduction of a triple mandate would allow social work(ers) to mediate societal and individual perspectives on social problems. Schmocker suggests that a social work approach that is based on the relational concepts of human dignity and social justice and legitimised with human rights has to get involved politically to address suppressive power relations (ibid.). Taking a decidedly human rights-based approach to social work would therefore include rendering the complexities of individualised problems (such as 'ADHD') visible and examining and addressing these in their wider contexts, with a specific focus on power relations. Instructive in this context are the counter-discourses that emphasise the importance of environmental factors in the lives of children. Such a stance would arguably challenge the biological reductionism that I elaborated upon in the first findings chapter. The following image visualises the triple mandate (the numbers reflect the priority from the perspective of social work):

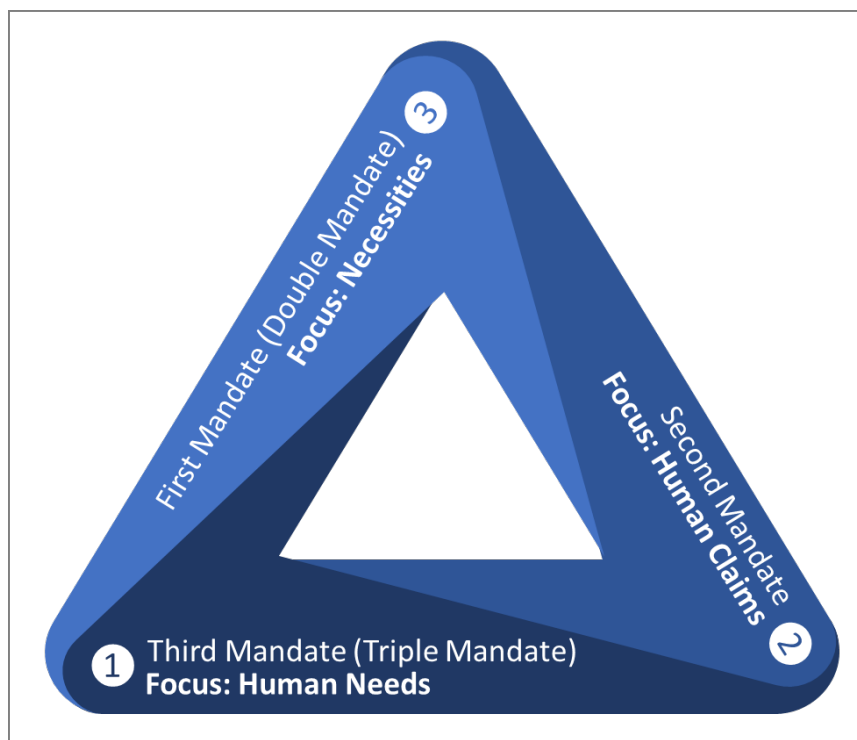


Figure 17: Triple mandate of social work, derived from Schmocker (2019).

The following table draws together the main characteristics of the three mandates, as discussed above:

	<b>Triple Mandate</b>	<b>Second Mandate</b>	<b>Double Mandate</b>
<b>Priority for social work</b>	First priority	Second priority	Third priority
<b>Basis</b>	Scientific Knowledge, professional ethics, human rights based on human dignity	Basic and legitimate human claims	Help and control
<b>Focus</b>	Micro-, meso- and macro levels	Individual micro-perspective	Societal macro-perspective
<b>Motivation</b>	Mediatively motivated	Anthropologically / social-psychologically motivated	Politically motivated
<b>Rationale</b>	Combination of societal and individual perspectives to address <b>human needs</b>	People affected by hardship, poverty or injustice know best what they need ( <b>human claims</b> )	The logic of social welfare organisations and the prevailing social policy determine the form of help ( <b>necessities</b> )

Table 5: Main characteristics of the mandates of social work derived from Schmocker (2019)

As I have argued, however, social work is almost completely absent on the discourse planes analysed. What can be said about praxeological concerns in this particular context is consequently very limited. A concrete example of how a human rights-based approach may take shape (here in the context of education and disability), though, has been demonstrated by Eckstein and Gharwal (2016). What can be done in the context of this thesis, however, is to indicate how the adoption of a triple mandate might be built upon both to empower people and to foster reflexivity within social work (practice). It is to these two perspectives that I now turn.

## Emancipatory Perspective

The triple mandate, as discussed above, emphasises the need to take into consideration the basic and legitimate claims of individuals. A possible approach to adopting such an emancipatory perspective is the introduction of

a 'standpoint epistemology of suppressed types of knowledges' as proposed by Hanses (2007, p. 318). As I discussed in the literature review (cf. **Professionalism**, p.23), scientific and professional knowledges enable practices that are entangled with power. The first analytical chapter examined some of these knowledges and suggested that they tend to reduce complex social problems to medical 'illnesses' in need of treatment.

For instance, in the context of ADHD, discursive practices seek to render children knowable and governable by abstracting their behaviours from their complex lived experiences. The 'ADHD child', thus, is constituted through the generation of specific knowledges that are perceived useful for professional (medical) practices. This is particularly visible in the *German Guideline on ADHD* (DGKJP et al., 2018a). As I have argued, this guideline tends to strip children from the complexities of their lived experiences and to subject them to a number of recommendations that emphasise what is considered the 'best clinical practice' of medics rather than the human needs of children.

Social work, Hanses (2007) suggests, should not join these approaches by generating its own canon of discursive expert knowledge. Rather, an emancipatory approach would turn its emphasis to the experiential knowledge of children and their families. Such an approach would bring the subject and their concrete lived experiences back into the discourse. Furthermore, it would give children and their families a voice and would enable social workers to learn more about their needs and aims in the context of concrete lived experiences and in relation to their specific life-worlds.

The findings of this thesis suggest that although recent shifts in images of childhood (cf. the Athenian image, Smith, 2012) highlight notions of participation and agency in children, the ways we implement these are potentially manipulative rather than empowering. I therefore argue that the case of ADHD may be considered as an example of how children are muted, not despite but indeed through practices that aim to foster advanced liberal subjectivities. The way the tutelary complex, including social work, tends to

see children (and indeed their families), appears to be still rather paternalistic and disempowering. This is particularly visible in the almost complete absence of children's own views and in the rather weak role of parents in the discourse on childhood ADHD in Switzerland that I have problematised throughout this research. For instance, as I discussed in the third findings chapter, parents are increasingly being reduced to allies in the medical assessment and management of 'mental health' in their children and may face pressure on the part of 'experts' if they decide to resist the medicalisation of their children's behaviour.

In acknowledging this social work may aim to build new knowledges about children and childhood in general and contemporary phenomena such as 'ADHD' in particular. By giving children and their families a voice, social work can open itself up to the complex and multifaceted lived experiences of children. Moreover, by treating children and their families as experts in their own lives, social work(ers) may find new, participative ways of building empowering knowledges about children and childhood. This also resonates with the second mandate that I discussed above that emphasises that those affected by adversities may know best what they need. However, through the introduction of a triple mandate, these claims on the part of individuals would then be mediated with a societal perspective (double mandate) and reflected in the light of both descriptive and explanatory social work knowledges, professional ethics and human rights. By being open and listening to the ways that children bring meaning and understanding to their life-worlds, social work(ers) may finally overcome the individual and psychological approaches that currently render children silent and subject them to interventions that fail to address the broader factors shaping their lives and experiences.

More recent approaches, building on indigenous knowledges, such as Family Group Conferencing (see, inter alia, Lupton, 1998), aim to remove such power imbalances by moving the ownership of decision-making processes to children and their families (Straub, 2011). However, even participative

approaches do not necessarily lead to anti-discriminatory and anti-oppressive outcomes. It is against this background that social work, adopting a triple mandate perspective, needs to continuously reflect on its own practices in the light of moral philosophical knowledges, in particular professional ethics. It is to this reflexive perspective that I now turn.

## **Reflexive Perspective**

Hanses (2007) suggests that a reflexive perspective concerns foremost the attitude of systematically attending to the context of the construction of knowledge and the practices enabled by these knowledges. I have argued throughout this thesis that in the discourse on childhood ADHD in Switzerland the emphasis on biological reductionism tends to render children pathological and in need of primarily medical interventions (see discussion of implications above). Additionally, I have problematised that these knowledges, which aim to reduce behaviour framed as 'ADHD' to the 'brain', are not neutral but entangled with power relations (for instance the links to the pharmaceutical industry) that do not necessarily empower children and their families. In the light of the further professionalisation, the adoption of a reflexive perspective would consequently require social work to include an ongoing critical examination of its own professional practices.

For instance, this would include critically reflecting on the images of childhood, (see second findings chapter) to de-construct them, and critically reflecting on the practices enabled by such images. As members of the 'tutelary complex' (Donzelot, 1980), social workers operate with a set of assumptions about children and childhood in their practice. Challenging these seemingly taken-for-granted assumptions (for instance 'developmentalism') is a prerequisite to deconstructing conceptualisations of childhood that frame phenomena, including 'ADHD' behaviour, in unhelpful ways. Whether we understand childhood in terms of the dichotomy of morality and immorality (the Dionysian image, cf. Jenks, 2005), adjustment and maladjustment (the Apollonian image, *ibid.*) or, more recently, responsibility and irresponsibility (the Athenian image, cf. Smith, 2012), we

need to be aware that such constructions have significant consequences, not only for children themselves but also for those around them, including social workers.

Bourdieu (1996) suggested a 'reflexive anthropology' to facilitate reflexivity. Such a critical-reflexive approach would include two dimensions. First, this would include examining the entanglements of power and knowledge in discursive practices that constitute the living conditions and shape the lived experiences of children and their families. This thesis may be regarded as a contribution towards this first dimension of reflexive anthropology. On a more practical level, this would also include the critical reflection of social workers on their own professional practice. Such a perspective would challenge notions of social work as a well-intended form of help that is per se emancipatory, even in contexts that are conceived of as decidedly empowering. This dimension has not been covered by this thesis and thus requires further research.

A critical awareness and reflexive approach to (sometimes subtle) forms of power and their (not necessarily intended) dynamics hence seems indispensable to foster empowerment in children, their families and the communities they live in. In this context the triple mandate provides the means of continuously reflecting upon social work practice along the lines of professional ethics and in the light of principles of human rights and social justice.

## **Conclusion**

This section has elaborated briefly upon how the introduction of a 'third mandate' (cf. Staub-Bernasconi, 2011, 2007) together with a praxeological, emancipatory and reflexive perspective (cf. Hanses, 2007), may lead to advancing social work towards anti-discriminatory and anti-oppressive practices. More specifically, I suggest that the combination of these perspectives within the context of the further professionalisation of social

work might contribute to the creation of social spaces that value children (and their families) as human beings.

Such an approach would acknowledge the uniqueness, contextuality and complexity of each child's lived experience, rather than subjecting them to predefined categories of 'expert knowledge'. Through its hermeneutic character, the 'triple mandate' would allow the linking of social work interventions to biographical knowledge, while also mediating these with societal concerns and interpreting them along the lines of professional knowledges, ethics and human rights.

After these elaborations upon praxeological, emancipatory and reflexive perspectives, I now indicate some limitations of this research.

## **Limitations**

This study has taken a qualitative, discourse-analytic approach. Against this backdrop the findings presented throughout this research are inevitably illustrative rather than representative. Three key limitations that could be addressed in the context of further research projects include (i) the reliance on naturally occurring data, (ii) the dominance of linguistic data, (iii) the focus on the federal context.

The discourse theory approach that I have taken and discussed in the methodology chapter mainly relies on naturally occurring data, such as documents and mass media communications (see, *inter alia*, Wodak and Meyer, 2009). There are a number of advantages of such 'non-reactive data' (cf. Webb, 1966, p. 16). For instance, the use of natural occurring data is believed to avoid bias problems arising from questionnaires and interviews, including those in relation to sampling, the investigator and interviewees. While this thesis provides useful insights into the discourse on childhood ADHD in Switzerland, for example, through illustrating how the 'ADHD child' is constructed along representations of deviance, distress and self-governance, there are also inherent limitations owing to the type of data

collected. For instance, this thesis has illustrated that both children and social workers are almost completely absent in the discourse around ADHD. While the data was helpful in identifying these gaps, it did not provide any means to further elaborate upon the absence of these voices.

Another limitation of this study is the dominance of linguistic data. While language is an important aspect of discourse, and an important means of how the social world is structured, negotiated and understood, the analysis of discourse would be more comprehensive through including non-lingual elements (Jäger and Maier, 2010). For example, discourse analysis can be applied to architecture to explore the ways in which social spaces shape the lived experiences and socialisation processes of children in particular ways. Much of the spatial and temporal processes of discipline and normalisation that I have discussed throughout this thesis are reinforced through the specific architectural features of contemporary school buildings. While some of the images presented were valuable in the way they enabled considerations of some non-lingual elements of the discourse on ADHD (such as the examination of a picture showing a boy looking back into the camera while sitting in a classroom), the exploration of non-lingual elements of discourse could be expanded significantly.

For reasons of feasibility this research has primarily focused on the Swiss federal level, particularly in relation to the political discourse plane. However, given the federalist structure of Switzerland, much of governmental power remains with the cantons, including the monitoring of the prescription practices of medical doctors and the regulation regarding education. Hence this thesis is limited in that the discourse analysis undertaken, apart from a few exemptions, does not account for cantonal variety in (de-)regulatory practices. The inclusion of cantonal level legislation and practices would allow the drawing of a much richer picture of the discourse on childhood ADHD in Switzerland. Such an approach would potentially provide new insights into the cultural differences regarding diagnostic and prescription practices across cultural regions and cantonal authority.



## Future research

This thesis supports earlier findings regarding the ‘conspicuously absent’ (Harwood et al., 2017, p. 6) voices of children themselves in the discourse on childhood ADHD, both in Switzerland and beyond. Given the ethical concerns raised around drugging practices in children (see, inter alia, DGSP, 2013; NEK-CNE, 2011), future research is required to include children’s voices. Adopting a triple mandate perspective (see above), such research could generate new knowledges about children and childhood that could then be built upon to empower children. For instance, accounts of children themselves may well challenge the usefulness of medication, which is often assessed along parental and teacher satisfaction of the effects of medication (Leo and Lacasse, 2015). While some attempts have been made to include children’s accounts of ADHD (Esslinger and Schöbi, 2017; Haubl and Liebsch, 2010a; Singh, 2013), their involvement in the discourse still needs to be strengthened. On a praxeological level, new insights from children themselves might serve to develop models that involve children in all processes of diagnosis and interventions, rather than reducing them to passive objects (Davis, 2006, p. 55).

As I mentioned in the methodology chapter, I had initially intended to conduct research that was more engaging and participatory but felt that this would not answer my research questions. However, in future I believe that participatory action research would be particularly suitable to give children a voice. Furthermore, participatory action research is potentially (depending on the research design) in line with the ‘triple mandate’ approach and the values it emphasises. For instance, such approaches are reported to have positive impacts on community development in that they facilitate intergenerational dialogue through various forms of interaction, including youth-led workshops and regular meetings that are based on respectful relationships (Shamrova and Cummings, 2017).

Combining participatory action research methods with some of the findings of this thesis would enable further elaboration of the ways children experience

the world around them, and the environmental factors shaping their behaviour. In other words, such research might be employed both to further elaborate upon practices around ADHD and to develop theory-driven interventions. For instance, previous research has demonstrated how such research approaches may be built upon as a means to facilitate positive change in schools (e.g. Bautista et al., 2013; Soleimanpour et al., 2008).

As Shamrova and Cummings (2017) suggest, participatory approaches may really provide children and youth with an opportunity to become change agents in their communities. But they also argue that one of the main limitations of current research concerns the involvement of younger children (i.e. children younger than 10 years of age). However, in the light of observations presented throughout this research, it appears crucial to include children of all ages. For instance, 'structural violence', such as recruiting pupils into pre-schools at an ever earlier age and the transition from pre-school to school both appear to drive diagnostic and prescription practices in children in the light of 'ADHD' (and related 'disorders'). Hence, including these younger children appears crucial in understanding the complexities driving psychiatric diagnoses. As Shamrova and Cummings (2017, p. 407) further argue, the focus on older children and youth 'is a legacy of developmental psychology that emphasizes the lack of young children's critical reasoning'. In other words, the thought style at work here i.e. developmentalism may exclude children from participative research. Moreover, as I have argued earlier in this thesis, the conceptualisation of children along the image of the Athenian child may employ 'participation' in manipulative ways (cf. Smith, 2012). Aligning research design with the social work values and perspectives introduced above, though, might help to avoid such traps.

Arguably, adopting a participatory action research perspective would enable social workers to give children a voice, while simultaneously facilitating positive change. This, in turn, would render the capabilities of a triple mandate-based social work visible. In line with Schmocker (2019), I believe

that social work has much more potential to facilitate positive social change and could play a more important role in society than it actually does.

## Reflections

I discussed some of my personal values, interests and assumptions in the methodology (cf. **Researcher's Perspective**, p.73). Willig (2008) suggests both reflecting upon how these may have shaped the research and upon how the research may have personally affected the researcher. It is to these two dimensions of personal reflexivity that I am now turning. In common with some other researchers in the field (e.g. Abraham, 2010; Bailey, 2013; Timimi, 2005), I see behaviours displayed in children not primarily in terms of biological reductionism but in relation to environmental circumstances. I hold the view that children are subjected to a range of disciplinary measures and normalisation processes that are potentially harmful. Against this backdrop I see my research as a contribution towards anti-discriminatory and anti-oppressive practices in governing children and childhood, both within and beyond social work. Hence, I have taken a decidedly critical approach aimed at fostering positive social change, rather than simply describing the phenomenon of 'ADHD' and its entanglement with other discourses. Inevitably, this led me to focus on identifying counter-discourses and to problematising hegemonic positions. Although my aim is to empower children, my analysis has often drawn on categories and concepts relating to children's behaviour, foremost 'ADHD'. While it appears essential to use such categories when researching the discourse on children's 'deviant behaviour', the frequent use of such labels throughout this thesis arguably contributes to the popularisation of psychiatric diagnoses in unhelpful ways. My own use of such terms does in no way seek to endorse them with legitimacy and accuracy. Rather, I regard them as necessary tools for the analysis of their emergence in discursive practices.

In terms of the impact this research has had on me, I think it has foremost increased my knowledge and understanding regarding the discourse on childhood ADHD in Switzerland. In particular, the elaboration upon how

'scientific knowledge' is being constructed and disseminated has shaped my understanding of the claims to 'truth' in the context of ADHD and, more generally, psychiatry. In doing so, my research has strengthened my assumptions but also developed them further. For instance, while I assumed that the claims to 'truth' might be less scientific than political, the examination of the *German Guideline on ADHD* (DGKJP et al., 2018a) with the concepts proposed by Fleck (1979, 1935) significantly substantiated my initial assumptions. Above that, I was moved by the variety of labels used to describe children, many of which are potentially stigmatising. While examining their impact on children was out of scope of this research project, they nevertheless point to problematic power relations between children and adults. In addition, I have come to believe that contemporary conceptualisations of childhood (foremost the Athenian image of the advanced liberal subject) and spaces designed for children (foremost the formal education system) seem to lead to structural discrimination and oppression of children, in spite of (or indeed because of) more recent discursive shifts towards participatory (and indeed further) rights of children.

Let me conclude this thesis with some final remarks.

## **Conclusion**

This thesis illustrates the usefulness of a discourse analytical approach in social work research to examine the social complexities in the life-worlds of children, their families and the wider societal institutions around them. More specifically, the governmentality perspective taken locates the complex social phenomenon of childhood ADHD in Switzerland in its genealogical appearance and occurrence.

This research project has illuminated how the concept of ADHD is increasingly being adopted beyond the US, taking Switzerland, with its four language regions and its federalist structure, as a case example. Particularly insightful are the visual representations used throughout the discourse, adding a further dimension to the data. The following image is a collection of

the ten images presented throughout this research, of which each represents a sub-theme that emerged out of the data:



Figure 18: Collage of images presented and examined in this thesis

Drawing on Fleck (1979, 1935), the results illustrate how rather vague research findings regarding childhood ADHD are presented as objective, scientific facts. These simplified ‘truths’ are then built upon to transform political agendas about the government of children into apparently apolitical ones.

Additionally, the findings illustrate the usefulness of adopting a perspective in the tradition of the new social studies of childhood to examine how the image of the ‘ADHD child’ is constructed along (visual) representations of deviance, distress and self-governance. It is against these images that more recent regimes of practice aim to render children labelled with ‘ADHD’ (and, indeed, numerous other labels) ‘loveable again’ (Ciba-Geigy, 1971).

Furthermore, the results illustrate how children are governed through and within social spaces, i.e. the school, the family and leisure, suggesting that these are increasingly being meshed through the use of 'play' for both educational and therapeutic purposes.

Overall, the findings illustrate how knowledges around ADHD are entangled with power, giving voice to 'experts' and parents who are receptive to the medical model, while simultaneously marginalising opposing views. Of particular concern here is that both children and social workers are strikingly absent from the discourse on childhood ADHD in Switzerland.

The results suggest that the way we construct childhood has real consequences for children. While the move from psychoanalysis to pharmacology has shifted the blame from mothering to the 'brain', and re-conceptualised children from being 'bad' to being 'ill', the findings suggest that suppressive forms of governing their behaviour persist.

Avenues for future research include participatory action research to give children a voice and to initiate positive social change. The framework towards such transformational change along the social work core values of human rights, human dignity and social justice might be the triple mandate, as proposed by Staub-Bernasconi (2011, 2007) and further developed by Schmocker (2019, 2006).

As the way we think about 'mental health' in children, and the way we tend to address 'illness' in children is 'not a scientific, but a political decision' (Schmid, 2013), social work will need to become politically active if it were to initiate positive social change and foster sustainable communities. As such, social work bears a major responsibility, not only for the welfare of the individual child, but for the future of humanity.



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# Appendices

**Appendix A: Newspapers Used for Data Collection (p.346)**

**Appendix B: Brief Introduction to the Swiss Parliament (p.350)**

## **Appendix A: Newspapers Used for Data Collection**

This appendix briefly reviews the newspapers that form part of the data of this thesis. To locate their political positions, I draw on a spectrum from left to right as proposed by Blum (2004). Therefore, five political positions can be determined: (i) left (in the sense of a 'counter-discourse' for radical emancipation of the dependent); (ii) left-liberal (socio-politically reforming, for social commitment of the state); (iii) centre (equal distance to all sides, moderate), (iv) right-liberal (reformist in economic policy, aims to reduce the role of the State); and (v) right (national compartmentalisation, preservation of 'old values').

### **20 Minuten**

The newspaper 20 Minuten (meaning 20 Minutes) was founded in 1999 by the Norwegian media group Schibsted and has been published since 2005 by the Swiss media company Tamedia. In 2006, Tamedia founded the French edition '20 Minutes' and in 2011 the Italian edition '20 Minuti'. The commuter newspaper is published in tabloid format and presents news in its shortest form. The newspaper is distributed in boxes at railway stations and in larger cities and agglomerations according to the self-service principle. Compared to other newspapers it is particularly popular with younger readers. The name 20 Minutes refers to the average time a commuter spends in public transport on his/her way to work. There are five regional editions, Basel, Bern, Lucerne, St. Gallen and Zurich. The basic section of the newspaper is produced centrally in Zurich; the local editorial offices in the five cities each design two pages for their regional edition.

With a circulation of 424,592 and a reach of 1,332 million readers in 2019, the German publication is the most widely read daily newspaper in Switzerland (WEMF, 2019). The French publication has a circulation of 169,453 and the Italian version a circulation of 32,192 (ibid.). The political position of 20 Minutes is considered right-liberal (Bundeszentrale für politische Bildung, 2016). The archives of the 20 Minuten are available in

electronic format back to 1999 (German), 2006 (French) and 2011 (Italian). However, access is granted only through subscription.

### **24 Heures**

The newspaper 24 Heures (meaning 24 hours) is the highest circulation French-language, Swiss daily newspaper. The predecessor newspaper *Annonces et Avis Divers* was founded in 1762 as a weekly publication. Since 2005, 24 Heures has been published in four regional editions. The daily newspaper is owned by Tamedia. With a circulation of 49,107 and 168,000 readers, it is the largest newspaper in French language in Switzerland (WEMF, 2019). Its reporting quality is above average (Stifterverein Medienqualität Schweiz, 2018). The political position of 24 Heures is considered left-liberal (Blum, 2004). In collaboration with the Swiss National Library, the cantonal and university library of Lausanne and Tamedia, the entire editions of the *Feuille d'avis de Lausanne* from 1762 to 2001 and of 24 Heures have been digitised and made available to the public online free of charge.

### **Blick**

The daily newspaper *Blick* (meaning look or vista) was established in 1959 as the first Swiss tabloid publication. The newspaper is published by Zurich based Ringier. It came under criticism because of tabloid journalism stories with badly researched, deliberately manipulated or partly fictitious data and images. The soft news (i.e. a market-centred journalistic style that combines information with entertainment) strategy and tabloid journalism has led to a below average quality of reports (Stifterverein Medienqualität Schweiz, 2018). The political leaning of *Blick* is left-liberal (Blum, 2004; Müller, 2014). With a circulation of 107,119 and 543,000 readers (WEMF, 2019), the newspaper is the second largest daily publication behind '20 Minutes'. The archives of the *Blick* are available in electronic format back to 1959. However, access is granted only through subscription. The article search also included the Sunday issue, called *Sonntagsblick*.

## **Neue Zürcher Zeitung**

The Neue Zürcher Zeitung (meaning New Journal of Zurich), is a Swiss daily newspaper of the media company NZZ-Mediengruppe based in Zurich. Founded 1780, it is known nationwide as a newspaper rich in tradition. This also makes it the oldest German-language newspaper in Switzerland being published today. The New Journal of Zurich is counted amongst the leading media in German-speaking countries and, according to its mission statement, represents a right-liberal orientation (Blum, 2004; Neue Zürcher Zeitung, 2015). The Journal enjoys a reputation as a quality newspaper (Stifterverein Medienqualität Schweiz, 2018). In addition to the business section, this is mainly due to its focus on foreign reporting, which draws on a dense network of correspondents. In 2018 the New Journal of Zurich had a circulation of 85,305 and 257,000 readers (Neue Zürcher Zeitung, 2019). In 2005 the complete holding of newspapers on microfilm was digitalised and made available for full text searches. A subscription is required to access these archives. All articles are available in portable document format (PDF). The article search also included the Sunday issue, called NZZ am Sonntag.

## **Tagesanzeiger**

The Tagesanzeiger (meaning daily gazette) is a nationwide Swiss daily newspaper from Zurich and is published by the Tamedia publishing house. Its focus is on the metropolitan region of Zurich (city and agglomeration of Zurich). Since January 2017 there has been a comprehensive cooperation with the Süddeutsche Zeitung (a German-language newspaper based in Germany). In addition to foreign reporting, the cooperation covers topics that do not always focus on a national perspective. These include the areas of knowledge, culture and society, and sport. The Tagesanzeiger was founded in 1893. With a circulation of 130,957 and 460,000 readers, it is the largest subscription newspaper in Switzerland. Its political position is considered left-liberal (Blum, 2004; Longchamp, 2013), while the position of the Sunday issue Sonntagszeitung is considered centre (Blum, 2004).

The archives of the Tagesanzeiger are available in electronic format back to 1980. However, access is granted only through subscription. The article search also included the Sunday issue, called Sonntagszeitung.



## **Appendix B: Brief Introduction to the Swiss**

### **Parliament**

The Swiss Confederation is neither a purely parliamentary nor a presidential democracy but has developed a system of government that is largely of its own character, called the directorial system (Krumm, 2013). It consists of a national two-chamber parliament, the National Council and the Council of States, and the Federal Council, which unites both the collective heads of state and the federal government. Switzerland is a federal state with a comparatively high degree of autonomy in its member states (cantons) and involves municipalities in all phases of political decision-making. Through the popular initiative and referendum, citizens can exert direct influence on the activities of the municipal authorities, the cantonal parliaments and the federal parliament, as well as beyond the parliaments. Switzerland's political parties are strongly influenced by federalism. The larger parties are usually active at federal, cantonal and communal level through cantonal and communal sections, whereas many small parties confine themselves to political work in their canton or commune.

The most important parties in Switzerland are the so-called federal council parties. These are the parties with the most voters and at least one representative on the Swiss Federal Council. One of the distinctive features of the Swiss political system is its stability. Four parties have been represented in government for decades and predominate: Swiss People's Party (SVP, right-conservative), Social Democrats (SP, left), Free Democrats (FDP, right-liberal), and Christian Democrats (CVP, centre). Linking these parties back to the political position of the newspapers, Blum (2004) argues that those newspapers classified as 'left-liberal' may represent opinions of members of left oriented members of the FDP and moderate members of the SP. Publications classified as 'right-liberal' may represent opinions of right oriented FDP members and moderate SVP members. Finally, those classified 'centre' may best represent CVP party members. As mentioned before, these classifications are not fixed but nevertheless help the reader to

develop a certain idea of the political landscape in Switzerland and how newspapers may be classified around certain political orientations.